

HEALTH CARE FOR DISPLACED WORKERS ACT OF 1983

HEARINGS BEFORE THE SUBCOMMITTEE ON EMPLOYMENT AND PRODUCTIVITY OF THE COMMITTEE ON LABOR AND HUMAN RESOURCES UNITED STATES SENATE NINETY-EIGHTH CONGRESS

FIRST SESSION

ON

S. 811

TO PROVIDE BLOCK GRANTS TO STATES FOR THE
PURPOSE OF PROVIDING HEALTH INSURANCE OR
HEALTH CARE BENEFITS TO UNEMPLOYED WORKERS

MAY 3 AND 9, 1983



Printed for the use of the Committee on Labor and Human Resources

U.S. GOVERNMENT PRINTING OFFICE

23-383 O

WASHINGTON : 1983

5541-32

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HEALTH CARE FOR DISPLACED WORKERS ACT OF 1983

TUESDAY, MAY 3, 1983

U.S. SENATE,
SUBCOMMITTEE ON EMPLOYMENT AND PRODUCTIVITY
OF THE COMMITTEE ON LABOR AND HUMAN RESOURCES,
Washington, D.C.

The subcommittee met, pursuant to notice, at 9:42 a.m., in room SD-430, Dirksen Senate Office Building, Senator Dan Quayle (chairman of the subcommittee) presiding.

Present: Senators Quayle, Kennedy, Randolph, Pell, Riegle, and Metzenbaum.

Also present: Senator Specter.

OPENING STATEMENT OF SENATOR QUAYLE

Senator QUAYLE. The committee will come to order.

This hearing has been called to discuss health insurance benefits for the unemployed. I do not believe we need to elaborate on the unemployment problem with which this Nation has been wracked over the past 4 years. Some of us, coming from the Midwest and other States that are hard-hit, know full well the ramifications of unemployment.

Today, we are going to examine a particular problem with the unemployed, and that is health insurance. I do not think there is any doubt that when an individual loses his or her job, that the health insurance a short time thereafter is also terminated.

I believe we have to do two things today. One, we need to establish the need for the role of the Federal Government in providing health benefits or health insurance for the unemployed. I believe that this contention will be supported by the witnesses that we have here today. And second we then have to figure out the best vehicle and the administrative procedure on how we are going to implement any kind of health benefits or health insurance for the unemployed.

Finally, there is a word of caution that there are certain budget constraints that we must all realize. We have a number of other committee meetings going on this morning. I will limit my remarks and would encourage the witnesses to try to keep their comments in summary form to 5 minutes.

The entire statements will be inserted in the record. We have a number of witnesses. There has been a lot of testimony before the Senate Finance Committee, which is available to this committee as

well, and I believe it would probably be most productive to go ahead and proceed with the questions.

I will yield at this time to Senator Metzenbaum, unless he would like to yield to Senator Randolph, who has to go to the Ruckelshaus hearing in Public Works at 10. I will leave that to your discretion, Senator Metzenbaum.

Senator METZENBAUM. I would be happy to yield.

Senator RANDOLPH. I thank the able chairman for permitting me a very brief statement, and I shall place in the record further remarks. I am grateful also to my colleague from Ohio for permitting me to be present for these few words.

I am not a member of this subcommittee, but I want the record to show that I am intensely interested as a member of the full committee, as we all are, and as the capable Senator from Pennsylvania, Mr. Specter is, in the issue being discussed here today—the issue of providing health insurance for the unemployed.

Mr. Chairman and Senator Kennedy, and all who are here, unemployment is a terrible sickness. It stalks the land, robbing us of a productive work force and economic health. More importantly, it is devastating to those who are jobless, to the workers that are not employed, and it is a tragedy, often, to the families of those individuals. There is a sense of helplessness, even sometimes, uncontrolled anger, and it creates, certainly, a climate of deprivation which is not good for America.

Currently, 21 percent and a little over of the work force in West Virginia is unemployed—that is the highest in the Nation—and that unemployed group is facing the hardest economic times that we have seen in almost 50 years. Twenty-one percent unemployment, we must remind ourselves, is more than twice the national average, which reaches what I call an unconscionable figure of 10.3 percent. Twenty-one percent unemployment in West Virginia means that 100,000 workers in West Virginia are out of work; however, these jobless workers have not stopped looking for work. They continue to search, but they are unable to find the jobs that they need and deserve. And nearly one-third, or 51,000, of the West Virginia unemployed have been without work, we should remember, for a period of more than 27 weeks. 25 to 30 percent of our coal miners are unemployed—Senator Metzenbaum would have an understanding of that because of Ohio coal miners, who are in the same plight as in West Virginia. One of our coal mining towns, Gary, W. Va., in McDowell County, I say to all of you, has an unemployment rate of 90 percent. Ninety percent. In addition the steelworkers, the chemical workers, and the glass workers, and the footwear workers, among others are unemployed, In West Virginia, and they are, at this time, being hurt by certain economic policies. And so, not taking any longer, but asking permission to place my full statement in the record, I do want to end by saying that there must be some equitable, some realistic way to supply, insofar as possible work for the workless—jobs for the unemployed. We must do what we can through constructive programs to meet these demands.

One very real problem that results from the high unemployment rate of our Nation, and one which must be dealt with through such constructive programs as mentioned previously, Mr. Chairman, is

the fact that many of our jobless workers in our State and nationwide, are without health insurance coverage, and these tragic figures include the families of the unemployed who are deprived of adequate health care. Let us hope that this problem can be alleviated, if not eliminated, through enactment of this legislation, providing for health insurance for the unemployed—that we are hearing testimony on today.

I again thank the chairman and members of the subcommittee for indulging me this opportunity to bring certain facts that I hope will be helpful to the record of the hearing.

Thank you.

Senator QUAYLE. Your entire statement will be inserted in the record.

[The prepared statement of Senator Randolph follows:]

PREPARED STATEMENT OF SENATOR RANDOLPH

Senator RANDOLPH. Mr. Chairman, unemployment is a sickness that stalks our land, robbing us of a productive work force and our economic health. More importantly, it is devastating to the jobless workers, and it is a tragedy for their families. Unemployment creates frustration and a sense of helplessness, and anger. It also creates a climate of deprivation. The adjustments required for a family stricken by unemployment are often hidden from friends and others, at a time when friendship and help is most often needed.

It is demoralizing for men and women who have been productive workers all their lives to accept the reality that a job is not available to them. And it is an indictment of our economic decisions that people do not have jobs.

Mr. Chairman, 21 percent of the work force in my State of West Virginia face these cold, hard, economic facts squarely each day. Twenty-one percent unemployment is more than twice the national average which already stands at an unconscionable 10.3 percent. Twenty-one percent unemployment is more than twice the national average which already stands at an unconscionable 10.3 percent. Twenty-one percent unemployment in West Virginia represents the highest rate for any State since the Government began recording statistics by States in the late 1960's. Twenty-one percent unemployment in West Virginia means that at least 160,000 workers in my State want to work but cannot find a job, and nearly one-third or 51,000 of West Virginia's unemployed have been without work for more than 27 weeks. Perhaps that number is higher because many people in despair have given up looking for work, and they are no longer counted as part of the labor force.

Almost 30 percent of the coal miners in my State are unemployed, and in some towns and counties it is much worse. For example, McDowell County has an average of 35 percent and Gary, W. Va., a little coal mining town in that county has 90 percent unemployment. Steelworkers, glassworkers, footwear workers are all unemployed in West Virginia and they are being trampled by our economic policies. Mr. Chairman, we must provide jobs for the unemployed, and we must care for their needs until the jobs are created.

Let's look at these statistics in human terms for a moment. Behavioral scientists tell us that despair and depression among jobless workers is a serious problem and becoming worse as the general perception that a recovery is just around the corner becomes more prevalent in the media. The have-nots see that the haves continue to prosper and there is a growing feeling that no one cares about those without jobs—those who have become accidental victims of the recession. There is no recovery in West Virginia, there is just a deeper catastrophe for jobless workers and their families.

It has been estimated that as many as 100,000 jobless workers in my State are without health insurance coverage and this overwhelming figure does not even include families of unemployed, who are subsequently deprived of adequate health care.

About a month ago a group of men were visiting with me in my office. Their purpose in coming to Washington was to remind us that unemployment is still with us, and that people were enduring daily suffering. One strong, highly skilled young man told me that he had been unemployed for nearly 2 years, he had a wife and four children, the youngest one only 3 months old. He told me that he had no health insurance to pay for taking his children to the doctor when they were sick, and he had no way to pay for his wife and infant's hospital care. In desperation, he had literally begged the hospital for a chance to honorably work at sweeping floors to pay the hospital bills. His offer was turned down, and the bills just keep coming. He cannot pay them and is at a loss how to handle those debts.

This young man is just one individual, but his situation is multiplied by millions. The Congressional Budget Office estimates that 11 million Americans have no health insurance because the chief family breadwinner is unemployed. The Labor Department estimates that health care coverage is lost within a month of the job loss for 50 percent of the unemployed workers. Three months or more of coverage is available for only 20 percent of the jobless workers. Within 6 months, virtually every unemployed worker loses health care protection.

Health care for jobless workers must be a priority. There are several proposals to provide health coverage before the Senate, and that is an encouraging sign. I am supportive of these efforts and hope that we can move legislation quickly. The human needs are there Mr. Chairman, and they are crying out to us today. I hope that compassionate economic policies will be our goal and our guide as we proceed.

Senator QUAYLE. Senator Metzenbaum.

Senator METZENBAUM. Mr. Chairman, I first want to commend you for holding these hearings today, on what is rapidly becoming a major public health problem in this country. In all honesty, in the last 2 years, you have shown your willingness to step out with respect to retraining and in connection with other matters of concern, and I do commend you for that and hope that we continue to have that kind of a working relationship.

There are 10.7 million jobless Americans who are in danger of being deprived of their basic health insurance coverage, and as the Senator from Ohio, I know that I do not have to remind the Senator from Indiana about the terrible human costs of unemployment.

Your State and mine have suffered disproportionately from the current recession.

I see Senator Specter about to speak; Senator Randolph has spoken; Senator Pell, Senator Kennedy—all of us know the terrible human tragedies, not alone of unemployment, but of the impact upon the family of the loss of health coverage when unemployment occurs. Unless we act immediately to provide assistance to those in need, our States and the Nation as a whole will in future years pay a terrible price for medical problems that are today going untreated.

It will be penny-wise and pound-foolish if we do not spend those necessary dollars to provide adequate health care for the unemployed of this country.

The evidence is already coming in. For the first time in decades, the trend in infant mortality rates has reversed. Infant mortality is now increasing in those States and cities with high unemployment rates. Hospital emergency rooms are crammed with those who have nowhere else to turn, and some hospitals are closing their doors entirely to the poor. And with the advent of more and more for-profit hospitals, it only exacerbates the problem.

Other hospitals are on the brink of financial disaster because of a need to handle more patients at the emergency rooms. Physicians and hospitals are also seeing persons with serious, life-threatening health problems which could have easily been treated at an earlier stage.

On paper, this Nation's health care system looks good: Medicaid for the poor, health insurance for the workers, and medicare for the elderly and disabled. The problem, Mr. Chairman, is that it is just not working. Our medical system is full of gaping holes, and there is no way to fill those holes without spending the necessary dollars.

The Reagan administration, however, believes that we can solve the problem without spending money. The Reagan administration somehow thinks you can do it on the basis of voluntarism.

How do they propose to do it? First, the administration relies heavily on the voluntary effort of the Nation's physicians. But let me quote to you from a recent letter sent by a for-profit hospital to all of its physicians. "We all give a lot of free care out of a sense of humanity and good public relations. To maintain our financial viability, it is essential that we minimize our benevolence." I am sure that many doctors are providing free care, and I commend them. But I am afraid that this letter is also typical of an attitude in the medical profession that is widespread enough to insure that voluntary efforts will not suffice.

Last week, for example, my staff conducted a survey of 12 Ohio cities and towns to determine what type of care is available to an unemployed person who cannot pay for a doctor visit. The findings are not reassuring. While three of the largest cities in Ohio had set up referral programs, in more than half of the cases, the local medical society could not give us the name of a single physician who would see a patient without charge.

Finally, Mr. Chairman, I believe that the low rate of doctors accepting medicare assignments speaks volumes about the potential of voluntarism. Only about 50 percent of doctors are willing to

accept assignments, and most who refuse give as their reason the fact that medicare does not pay enough. Now, if doctors will not even accept a reduced fee for the elderly and the disabled, how can we expect them to see the unemployed for free?

The second part of the administration's proposal to provide health care for the unemployed is to allow the States to use their title XX block grant funds for this purpose. What a joke, what a laugh, what a pity that is. Title XX funds pay for day care programs, elderly nutrition programs, home health care assistance, and other vital services. These funds were cut by approximately 25 percent in the first year of the Reagan administration, and States have been forced to make severe cuts in social programs as a result.

Now we have the administration proposing that States could cut these programs even further in order to provide health care for the unemployed. Aside from David Stockman, I do not think there are many who would consider that a reasonable solution.

The third part of the Reagan administration's proposal says that if we do have to spend any additional Federal dollars on this program, let us tax employees' health insurance benefits in order to pay for it. This is the same administration that claims it does not want to raise taxes and will veto a budget resolution that includes tax increases. I think we need to recognize that there is no such thing as getting something for nothing. We now have to pay the price of the disastrous unemployment which our economic policies have wrought.

Last week, Senator Kennedy and I, along with the other Democratic members of this committee, introduced a bill to provide assistance to the States for health care for the unemployed. Some will criticize the bill and say it is too costly. In fact, it will provide only a bare minimum of needed medical services. I urge this subcommittee to act quickly on this bill. In the end, it is a small price to pay for assuring the health and well-being of this country's working families. We owe them no less.

Senator QUAYLE. Senator Kennedy.

Senator KENNEDY. Thank you very much, Mr. Chairman.

I, too, want to express my appreciation, along with Senator Metzenbaum, for your willingness to hold these hearings on a matter of enormous importance and consequence to millions of men and women and children, who no longer are covered with adequate health insurance. I am grateful to you for giving an opportunity to vent this issue and I welcome the Senator from Pennsylvania, Senator Specter, for his presence here today. I think it is quite clear that this is not a partisan issue, and that there is an extremely important need. I share the concern of my colleagues, who have had the opportunity to review the administration's position as presented by Mr. Stockman to the Finance Committee. Mr. Stockman has concluded that the problem of lack of health insurance among the unemployed is one of "selective gaps and discontinuities and not a pervasive or general problem." That kind of comment could only be made by one who has not talked to the unemployed men and women of this Nation, in my own State of Massachusetts and throughout this country.

There is not a Member of the U.S. Congress who has not heard the heart-breaking situations faced by the unemployed. Statistics are quite clear. The Congressional Budget Office has documented them. We know of them in our own States. There is a significant, ongoing, and continuing problem that is growing every day.

I am mindful of the statistics of increases in infant mortality in some of our most hard-pressed States. The problem, Mr. Chairman, is that by failing to address this issue, particularly for primary care, prenatal care, preventive care, we are condemning many children to continued and ongoing illness and disease. In many instances, it is going to be irreversible.

We talk about dollars and we talk about budget and we talk about the amounts that are going to be expended by this Congress. We should not lose sight of the fact that it is going to cost billions of dollars more if we do not address these crucial needs now, let alone the anguish and the suffering and the pain that go along with it.

I would just like to mention one particular family. This situation could have taken place in any part of this country. Barbara and Tom live in a rural community. They have two children, ages 4 and 6. By using a home pregnancy test, Barbara learned that she was expecting their third child early last year. At the auto parts factory where Tom worked, production slowed, and Tom was laid off. The family lost their health insurance. Barbara's doctor refused to take her unless she paid \$600 in advance. She tried other doctors. Each time, the reply was the same: "Go to the clinic."

No real direction, no real help. Since Barbara's first two children were healthy, she decided not to worry about a doctor. In fact, the first doctor she saw was the doctor on duty when she arrived at the hospital in labor and gave birth to a 12-pound stillborn baby. Later, Barbara learned that she had developed a pregnancy-related form of diabetes which could have been treated easily if she had received help in time, and chances are that she would have given birth to a healthy baby.

This story is not unique. It is happening across the United States, and we will hear dramatic testimony to this effect. It seems to me imperative, Mr. Chairman, that we, in this committee, take action, and that the Congress of the United States meet its responsibilities to the millions of Americans who today are constantly worrying, every morning, every night, whether their child is going to become sick and whether they are going to have to sacrifice the food on their table or heat in their homes, or some vital, other need for their families to meet the doctor's bills.

I know it is a sense of compassion that has motivated you to have these hearings. I am grateful to you for having them, and I hope we can meet our responsibility to address this need.

I would like to ask that my complete statement be included in the record.

Senator QUAYLE. It will be included in the record.

[The statement referred to follows:]

PREPARED STATEMENT OF SENATOR KENNEDY

Senator KENNEDY. Mr. Chairman, the United States has just suffered through the worst recession since the Depression—and now we are suffering through one of the weakest recoveries. More than 11 million Americans are out of work. Businesses and farms continue to fail throughout the Nation—and workers continue to lose their unemployment benefits.

Today, we consider one of the worst consequences of this deep recession—the loss of health insurance that too often compounds the tragedy of unemployment.

The dimensions of the problem are staggering. The Congressional Budget Office estimates that over 10 million Americans and their dependents have lost their health insurance because they lost their job. Millions are forced to go without essential health care because they face the cruel choice between paying the bill for food and rent, or paying the doctor's bill. Infant mortality is rising in hard-hit States, where the number of women who receive no prenatal care has tripled.

But these are only the bare statistics. The real human tragedies are even more compelling. Governor Celeste of Ohio has told of one such family:

Barbara and Tom live in a rural community near Toledo. They have two children, ages 4 and 6. By using a home pregnancy test, Barbara learned that she was expecting their third child early last year. At the auto parts factory where Tom worked, production had slowed and Tom was laid off. The family lost their health insurance. Barbara's doctor refused to take her unless she paid \$600—cash in advance. She tried other doctors, and each time the reply was the same: "Go the clinic." No real direction, no real name, no real help. Since Barbara's first two children were healthy, she decided not to worry about a doctor. In fact, the first doctor she saw was the doctor on duty when she arrived at the hospital in labor, and gave birth to a 12-pound stillborn baby.

Later, Barbara learned that she had developed a pregnancy-related form of diabetes—which could have been treated easily if she had received help in time and the chances are that she would have given birth to a healthy baby.

Barbara's story is not unique. All across the United States, unemployed workers have lost their health insurance and lack the resources to pay for health care for their families and themselves.

The surest way to address this problem is to put America back to work. Only by reversing the administration's reactionary economic policies can we truly offer hope to the struggling families of America.

But it is not enough simply to wait for the recovery. Health care is too important to be sacrificed on the altar of supply-side economics. No pregnant woman should be denied prenatal care because she and her husband are unemployed and cannot pay the doctor's bill. No workers should lose their health insurance because they lost their job. No families should lose their access to health care because they have become casualties of the administration's unfair war against inflation.

We will hear from some of these families now. They will tell us of the struggle to feed their families, meet the rent, and pay the doctor. I wish David Stockman were here today to tell these working men and women why he thinks health care for the unemployed

is not a pervasive or general problem. Let Mr. Stockman explain to them why voluntary efforts can do the job, and why a Federal role would be the height of fiscal responsibility. I reply, the administration's fiscal responsibility has caused this problem, and they have no right to walk away from it. It is time for Mr. Stockman to pay something more than lip service to his social safety net. Mr. Chairman, I have introduced legislation along with Mr. Riegle and other colleagues on the committee to provide reasonable health care for the unemployed. I hope we can work together, in the bipartisan way that we have done in the past, to develop effective legislation and to persuade the administration to join us in this essential undertaking.

Senator QUAYLE. Senator Pell?

Senator PELL. I have no statement, Mr. Chairman, except to commend you very much indeed for holding these hearings on a subject which cuts across party lines, national lines, all lines. It disturbs me when one party thinks it has a monopoly of virtue, or another. I think this is an issue on which we should, I would hope, march together, under your chairmanship, and I think you are doing a great job in this direction.

Senator QUAYLE. Thank you very much.

It is not one side or the other. This happens to be a concern on both sides. We are concerned about the unemployed, about the lack of health coverage, and the human sacrifice, and the problems that go with it.

Senator QUAYLE. Today, as our kickoff witness, the Senator from Pennsylvania, who has introduced S. 811, with his colleague from Pennsylvania.

We are delighted to have you with us, Senator. We appreciate you getting out front on this issue. Go ahead and then we will ask a few questions.

Senator METZENBAUM. Is he unemployed?

Senator QUAYLE. He is not up until 1986. [Laughter.]

STATEMENT OF HON. ARLEN SPECTER, A U.S. SENATOR FROM THE STATE OF PENNSYLVANIA

Senator SPECTER. Thank you, Mr. Chairman.

I join the earlier statements of commendation for the chairman's actions in convening this hearing, and I commend the subcommittee for this prompt attention to this very important problem.

The problem has already been stated eloquently by those who have spoken from the panel on the human suffering and the widespread nature of unemployment and the resultant loss of health insurance.

Let me add very briefly my own experiences on this subject. Pennsylvania is a State which has suffered very heavily from unemployment, in the range of 13.2 to 13.8 percent over the past many months, and a much higher rate of unemployment in western Pennsylvania. I was in Erie and Meadville and New Castle and Beaver Falls over the past weekend, and in those communities, the frequent unemployment rate was in the 22-percent range, because those are steel communities, and they have been hit especially

hard by problems of unemployment and the loss of health insurance.

I began to hear a great deal about the loss of health coverage during the course of late 1982, and it came to a crescendo when Senator Heinz and I had an open house town meeting in Midland, Pa., on March the 5 of this year—a town which lost 4,500 jobs in one fell swoop when Crucible Steel closed. And when Senator Randolph talked about Gary, W. Va., at a 90-percent unemployment level, Midland, Pa., may well have topped that astronomical figure. On that Saturday when Senator Heinz and I went to Midland and met with a crowded high school auditorium, the No. 1 item on the agenda was the problem caused by lapse of health coverage.

Senator Heinz and I decided that we would direct our attention to the problem, a close second with the problem of mortgage foreclosures. There were many problems on the agenda that particular day—natural gas, and many, many others. But it was our thought, coming from Pennsylvania, that the problem which required the most immediate attention was health insurance coverage for the unemployed. We introduced Senate bill 811 on March 15, and I believe it was the first bill of this kind introduced. Senator Riegle has another bill with a significantly different direction.

We were able to attract President Reagan's attention to the specific problem when he visited Pittsburgh on April 6. In the ride from the airport to the downtown meeting, the President asked about the kinds of questions that he might face in the Q. and A., and we informed him about the problem of lapse of health coverage, and sure enough, the President got a question on this subject, in a very spontaneous and genuine way. And, as the national news media later commented, that was the only new item which came out of that particular day's events. Naturally, there is always some inquiry as to what is new, and that did happen to be a new item. And while the President did not make a commitment, he did express a concern about this issue, and I think a fair statement would be that he was interested in finding a solution to it.

Now, as you know, Mr. Chairman, we had a meeting in the White House last week with Mr. Stockman, Mr. Meese, Senator Dole, Senator Heinz, Senator Durenberger, Senator Hatch, and you, and we are searching for a way to find an answer, and an immediate answer, to this very important problem. I believe it is a very salutary thing that there is a two-track approach, with this issue being considered by the Committee on Labor and Human Resources, in perhaps some friendly competition with the Finance Committee, because there ought to be prompt action. Mr. Stockman testified last week that the administration was looking for a way to avoid any additional expenditures on this problem, and while he did characterize it, as Senator Kennedy has alluded to, as not being a pervasive problem, Mr. Stockman did acknowledge that there were substantial gaps; where there were not two-employee families, and I think he put the figure at 2.4 million families who were without health insurance.

He is looking for something in the neighborhood of \$500 million, and some way to find new taxes; and if the Finance Committee can find that kind of funding, that would be superb. If they do not do that promptly, then I would join in the urgings already this morn-

ing from the panel itself that there be a prompt markup in this committee of this bill. I note that the House has already put in its budget \$2.7 billion, and the legislation that Senator Metzenbaum referred to, introduced last week by Senator Metzenbaum, Senator Kennedy, and others on this committee is moving forward, but it is a problem which ought to be addressed very promptly. There ought to be a signal to the unemployed in this country that the Congress cares and is moving with dispatch on this problem. Senator Kennedy expressed it eloquently in the specific case which he pointed out, that there is not a day to be lost, because every day which is lost, there will be thousands of cases where people will not get medical care which they need, and there will be other stillborn children, and there will be other people who will be suffering and who will sustain permanent disabilities as a result of not having the kind of medical care which ought to be available.

Mr. Chairman, I have a full statement, which I would ask be incorporated in the record, and you have already alluded to the fact that you have the testimony from the Finance Committee. I do not think the red light has been on too very long, so I will stop now.

[The prepared statement of Senator Specter follows:]

TESTIMONY FOR SENATOR ARLEN SPECTER BEFORE THE SUBCOMMITTEE ON
EMPLOYMENT AND PRODUCTIVITY (COMMITTEE ON LABOR AND HUMAN RESOURCES)
HEARING ON HEALTH INSURANCE FOR THE UNEMPLOYED
TUESDAY, MAY 3, 1983

Mr. Chairman, Members of the Committee, I thank you for the opportunity to testify before you today on the important issue of health care coverage for the unemployed. I applaud your interest in pursuing solutions to this complex problem and appreciate the opportunity to testify on Senator Heinz and my bill S.811, introduced March 15, 1983.

According to the Congressional Budget Office, almost 90 percent of the unemployed in the United States, or close to 11 million persons, have already lost employer-based health insurance coverage -- most within 30 days of job termination. In Pennsylvania, almost 400,000 people who have dependents receive unemployment compensation but have lost their health insurance.

Senator Heinz and I have collaborated for the past several months on a health program, and its importance was emphasized to us when we were in Midland, Pennsylvania about a month ago. A survey published in a Pittsburgh Press article, March 10, 1983, reveals that three of four of Mon Valley's unemployed are without any medical coverage. At least one of every five had immediate need of medical care.

In Washington, County, Pennsylvania, Canonsburg General Hospital is providing free medical service to unemployed workers and their families who no longer have insurance. The hospital workers have volunteered their services to help unemployed workers who live in the area and who have been delaying necessary

medical treatment and surgery for lack of income and insurance coverage.

But how long can hospitals, clinics, health centers and health service employees continue to absorb the increased costs? In Mobile, Alabama, for the month of March all of the hospitals but one had to close their emergency rooms on weekends to curb the flood of requests for free care in order to avoid bankruptcy.

Fortunately, for now, the county and city have been able to provide some assistance.

As of April 15, 1983, McKeesport Hospital (PA), a Hill-Burton recipient, had to lay off 51 employees "across the board". Twelve of these are nurses and three are Licenses Praticing Nurses. Some of the physicians indirectly have been cut back due to the losses the hospital is experiencing. This is a decrease of almost 3% in the hospital staff. Can we afford to run the risk of closed hospital doors nationwide?

In talking with various health providers, we are learning that many of the unemployed who are ill do not know where to go for treatment. We are discovering that one of the major fears of the unemployed is fear itself. The uncertainty of "what will I do if someone in my family becomes ill" plagues them constantly. Early action on health care legislation will help the unemployed find peace of mind with regard to health coverage. The unemployed workers need assurance as well as insurance that their needs will be met.

The Bureau of Labor Statistics has issued recent reports on the total annual consumption costs for both three and four-person families. It has calculated the national average weekly benefit under the states unemployment insurance programs. For example, a three person family accustomed to an intermediate level budget of \$14,960 would receive \$8,224 in unemployment compensation, which is approximately 55% of previously received income. Moreover, this compensation is only 5% more than the poverty threshold for a comparable family unit. However, if this family had no income, it would be eligible for \$10,164, nearly 25% more than the amount available through unemployment compensation.

I cite these statistics to make a point: many people who have worked hard all of their lives are now finding themselves in the unwanted situation of being a poverty level statistic and living below the poverty level.

Our original bill was intended to be a short-term, but immediate solution to the problem of lack of health care coverage for the unemployed. It was to give the states the revenues and the flexibility to establish a program which would service its constituency, including the options "to provide for cost-effective bidding among carriers or providers, or capitation reimbursement systems, while taking into account the existence of related programs or financing structures in given areas."

The states know best which areas are in most need and what facilities are available. While the ultimate solution would be to provide the unemployed workers with a health insurance policy

similar to what they have been accustomed, the costs most likely will be prohibitive. It is my understanding that Blue Cross of Western Pennsylvania has a proposal before the Pennsylvania Department of Insurance which would establish a low-cost health insurance program for unemployed people who have lost their benefits. The plan provides for up to 15 days of inpatient hospital care, at a cost of \$28.15 per month for individuals and \$62.20 for families or a 31-day plan at a cost of \$32.90 for individuals and \$72.90 for families. In Pennsylvania, the average monthly unemployment benefits is \$568. Carrying a policy for \$62.20 would be 11% of that family's monthly income.

Even if the government were to decide that health insurance coverage was the best way to go, and would subsidize the policies, say by \$52.20 for a 15-day policy for families and the unemployed had to pay \$10 of the premium, in Pennsylvania alone with 400,000 needing coverage, it would cost the federal government \$20,880,000 each month and \$250,560,000 per year. With a federal government subsidy of only \$10 per month per premium for 400,000 people, it would cost the government \$4 million per month, and \$48 million per year for PA. Still, those figures only include those workers who are receiving unemployment compensation.

And this is funding individuals and families who may never need medical attention within that year. My goal is to help those individuals who do have health problems when they occur and give all of those who have lost their benefits the peace of mind and

assurance that they will be covered when the need arises.

And this need not be as expensive a situation as one might first assume. In a report (Committee Print 98-A) prepared for the use of the House Subcommittee on Health and Environment, a 1974-75 study regarding high unemployment problems in those years is cited which "estimated that no more than 10 to 14 percent of workers losing group health insurance substituted individual nongroup health insurance. The probability of a two-earner household losing health insurance due to unemployment of the head of the household was reduced by 27%. Indeed, our plan is meant to be a payer of last resort and an unemployed worker whose spouse has coverage would not be eligible.

In addition, in Pennsylvania, for 1982, the average length on unemployment compensation was for 18 weeks or 4 1/2 months.

While the period of unemployment does not necessarily coincide with the period of loss of benefits, it generally works out to the same amount of time as lack of insurance. This statistic may be important from the standpoint that the majority of unemployed are not going without coverage for an excessive amount of time to warrant the administrative details of signing up for an insurance policy. However, in the event that a catastrophe should occur or a chronic illness need attention in those few months, the unemployed need assurance that they will be treated. The additional burden of mental anguish over reimbursement should be alleviated from the unemployed worker.

In no way do I mean to downplay the graveness of the situation -- that should be apparent by my persistence in obtaining a meeting with the Administration, and various hearings, not to mention talking to the President personally on April 6. However, the urgency of the need leads me to strive for a workable and financially acceptable solution which can be implemented as soon as it is passed by Congress and signed by the President. This short-term solution should not be bogged down with red-tape and administrative nightmares which will hold up the process any longer.

I would like to take this opportunity to encourage the states to look at the existing health services such as community and migrant Health Care Centers, Health Maintenance Organizations, public hospitals and even the example in Detroit, Michigan, "Project Health Care." I understand that this project is operating successfully in a city which has had an overwhelming share of the unemployed problem. Briefly, it is a program which provides a health service referral network using the existing social service agencies. It has approximately 360 physicians who volunteer their services and see the patients in their office as they would any other patient. The system is able to handle 1000 patients per month and yet to date, it has not had to serve that many in any one month.

Reimbursement is worked out between patient and the doctor. It is my understanding that there have been no physician complaints

about unnecessary visits or abuse of the system, nor any complaints from the patients that they received second-class treatment. If hospital tests or treatment is required, the physicians use their same hospital privileges and the hospital usually has a social service counselor who assists the patient in determining suitable financial assistance. What is even more encouraging about the program is that the original funding for the program was a \$63,000 grant from the Hudson-Webber Foundation. That grant enabled the Greater Detroit Area Health Council to hire a coordinator to recruit the physicians and set up the system.

It is unfortunate that more accurate data is not available. However, I would like to share some recent statistics provided to me by the McKeesport (Pennsylvania) Hospital which has recently established a special program for the unemployed.

The first week of the "Health Concern" program, 100 people inquired about services. Thirty-five were in need of immediate care. Only 25 of those 35 were eligible for the program. Eligibility is based on total monthly household expenses in excess of total monthly income. Those ten who were ineligible were still on unemployment compensation. One of the patients who arrived was a single unemployed mother with three children who had a pace-maker which had not been checked for 18 months because she was afraid to go in due to lack of coverage.

Some of the unemployed patients now qualify for Hill-Burton (McKeesport is a Hill-Burton Hospital) which proves my point about

the long-termed unemployed now becoming poverty statistics.

Here is an additional figure which may be of interest.

In this same hospital's outpatient clinic, a survey was done for February and March of 1983. Within that clinic, 80% of the patients seen were unemployed. In McKeesport, as of February, 1983, unemployment rate equals 21%.

The McKeesport Hospital reports that it lost one million dollars in operating costs in 1982. Obviously, if additional funds were available, the hospital would not have had to release those 51 employees which I mentioned earlier. Through the block grant system, the states would be able to assist those health services providers which are located in high unemployment areas and which have seen dramatic increase in patients.

The Canonsburg General Hospital in Washington County, PA, is a private hospital where all of the employees have volunteered their services to help unemployed workers who live in the area and who are delaying necessary treatment and surgery for lack of income and coverage. The data provided to me by this hospital is that in the past two months, 120 unemployed workers or a member of their family have been given free health care. In Washington County, the unemployment rate equals 18.9%. Twenty out of the 38 active physicians in this hospital are participating in the program. One of the major concerns of the individuals taking advantage of this hospital's generosity, is not for the unemployed worker or spouse, but for the health of the children.

Once the states set up their mechanisms for providing health care, it is imperative that an outreach program be implemented to notify those eligible. A letter to all of those who were or are on the rolls of unemployment compensation during the designated eligibility period informing them of what the state has designed and where they can go for help is one simple method. Perhaps this letter could include a brochure on preventative health tips. This would provide the assurance, which I must emphasize once more, that government officials are concerned and are prepared to assist them in the most expeditious, yet economical, and equitable way possible.

It will take a tremendous commitment from the United States Congress and Government to help those people who have lost their health benefits through no fault of their own. Millions of men, women, children and even unborn children are being exposed to the hazards of poor health care due to unemployment.

The need for health care coverage for the unemployed can no longer be overlooked. We cannot run the risk of having the health of breadwinners and future breadwinners deteriorate to the extent that they may be unable to return to employment once the economy recovers.

Senator QUAYLE. I appreciate that you have observed the red light. Sometimes, we do not have that cooperation.

Senator, thank you very much for your testimony. I appreciate your leadership in this area.

I might begin where you ended up, do you think that it would be proper for this committee to go ahead, even though the Finance Committee appears to be proceeding with work in providing health benefits for the unemployed? Do you see any problem with that?

Senator SPECTER. I see no problem. I think it is desirable. I very much believe in the free enterprise, competitive system, and a little competition between Labor and Human Resources and Finance would be a salutary thing.

Senator QUAYLE. Also, you talked about the costs and the administration's proposal and the theory of pay-as-you-go. What is your position? Do you think that we should come up with the additional revenues and, I guess more specifically, what about financing it through a cap on health insurance?

Senator SPECTER. I would like to see it financed on a current basis, if that can be done, and done promptly. The desirability of that is that it would have administration approval, and we could get legislation through the Congress, signed by the President. If we could find \$500 million, that would be a good way to go. If that is not going to be done promptly, then I would like to see an alternative approach, which would be a block grant approach. I think it is always an impossibility in putting a precise dollar figure on how much it is going to cost. I would be delighted to start with \$500 million as opposed to \$2.7 billion to get the program in process and operative at a very early date and then come back.

Mr. Stockman talks about a tighter tax cap on health insurance benefits but presently he has no cap at all. He is talking about trying to bootstrap this particular issue with a cap on at \$175, and then he is going to limit it to \$160, and with the other \$15, pick up \$500 million. But he does not even have the cap on at \$175 at the moment.

I think it highly undesirable to see this issue involved in any other controversy. So the less controversial the proposal is, the better off the people who are unemployed without health insurance will be.

Senator QUAYLE. If promptness is a concern, don't you believe that a block grant-type approach would be the best way to go to get speedy implementation of such a program?

Senator SPECTER. Yes, I do, and—

Senator QUAYLE. Which block grant? Have you looked at going through title XX as the administration is talking about, or a health block grant?

Senator SPECTER. I have looked at title XX, and that does not fall high on the priorities, for the reasons that Senator Metzenbaum articulated, but it would be a good stopgap measure if it were only the first step, because the States cannot use the block grant funds now in existence unless there is legislative change, and I think this problem is so important that the earlier we get to it, the better. I am aware of the fact that if we approach it, through title XX, that it may cool congressional ardor on this subject.

Senator QUAYLE. One final question, Senator. In your statement, you made reference to 1982 and a town meeting-type situation, when you became impressed with the severity of the problem and therefore the need, and you have had followup discussions with the President coming in, and other public discussions. I wonder, has your volume of mail increased and changed over the last year on health care to the unemployed, and could you describe what kind of mail you are receiving from the unemployed, requesting health care benefits?

Senator SPECTER. Senator Quayle, your staff had told my staff of your interest in that issue. We have taken a look at it, and I am told that we have a very small amount of mail. I frankly doubt the report that I have had, which is in the range of 30 letters, based on what I have sensed otherwise, and I am having a followup check. Every day I get about 1,500 letters, and frankly, it has been hard to keep track of the mail in the light of the avalanche on the withholding tax issue.

It may be that the small amount of mail is explained in terms of this group not being very enthused about writing, being a very discouraged group. But I know from what I have seen in the field at the open houses that it is a real and big problem, and I have related to you the high priority given at Midland, and I have also visited many hospitals, and the comments that I have had at Allegheny General Hospital, for example, in Pittsburgh accentuate the kind of a problem, where people are coming there and do not have health insurance, and there has been a great deal of voluntary care. And I think the medical profession has responded substantially, but there are limits as to how much can be given on a voluntary basis.

So I cannot pose an overwhelming case from correspondence, but my judgment is that there is one nonetheless.

Senator QUAYLE. Is that 30 letters you found from researching—what kind of time reference is that? You can submit that for the record.

Senator SPECTER [conferring with staff]. I will give you the details on the correspondence, Senator Quayle, because I am not satisfied with the search that we have had today. But in the light of your question, I want to be totally open with you as to what we have found at the moment, and I shall supplement.

Senator QUAYLE. Senator Metzenbaum.

Senator METZENBAUM. I have no questions. I very much appreciate the statement of Senator Specter, and I think it is important that we hear from the witnesses.

Senator QUAYLE. Senator Kennedy.

Senator KENNEDY. Thank you.

As you know, there are different unions, and employers have different periods of time for which they have coverage after layoff. I do not know what it is with regard to the mine workers.

Senator SPECTER. I think it is just 30 days, Senator Kennedy.

Senator KENNEDY. Thirty days?

Senator SPECTER. That is the standard which I have seen in the policies I have examined.

Senator KENNEDY. Most of them are 1 to 3 months. The UAW is a year. You take the number of people, I would think, in western Pennsylvania, with the unemployment at what level now—

Senator SPECTER. In western Pennsylvania, it depends on the county. It is 24 percent in Beaver County.

Senator KENNEDY. And those are mostly steelworkers?

Senator SPECTER. Mostly steelworkers.

Senator KENNEDY. And most of those individuals have been unemployed for what period of time?

Senator SPECTER. In excess of 6 months. Many, in excess of a year.

Senator KENNEDY. Yes. So most of them have lost their coverage, haven't they?

Senator SPECTER. Yes, they have. I would say that in Pennsylvania, 90 percent of the unemployed have lost their coverage.

Senator KENNEDY. One of the suggestions that Mr. Stockman has mentioned is that, first, the administration believes that much of the present hardship can be alleviated by constructive actions by the States. Now, what is the financial condition of Pennsylvania in terms of availability of resources for this kind of thing?

Senator SPECTER. We have one of the top two or three unemployment compensation bids from the Federal Government—

Senator KENNEDY. Well, what is your budget? Is it in surplus in Pennsylvania?

Senator SPECTER. It must be balanced under the State constitution, so there may be a surplus of a dollar; little more.

Senator KENNEDY. But I imagine you are hard-pressed.

Senator SPECTER. Very much so, Senator Kennedy. There are no funds available in the Pennsylvania coffers to take up this plan.

Our Governor, Governor Thornburgh, has taken the initiative in seeking a private plan in western Pennsylvania, a unique plan by Blue Cross, and it is at about half the regular rate, but it is still more expensive than most people can afford when unemployed.

Senator KENNEDY. To get the money, I suppose that means additional taxes. Are any of the political leaders there suggesting additional taxes in Pennsylvania, given the economic problems that you are already facing, to offset this particular problem?

Senator SPECTER. Not only no political leaders, but no nonpolitical leaders.

Senator KENNEDY. I think it is quite unrealistic in the States that are hardest-hit in terms of unemployment, to expect that they are going to have the resources to be able to deal with this issue. Now, can you indicate to me under your proposal—I think the chairman has pointed out that we have to try and reach some kind of a figure if we are going to address this issue. I had mentioned to our chairman that the bill that has been introduced by Senator Specter has been referred to our committee, so it is entirely appropriate that we address both that legislation plus the legislation that I and others have introduced.

How many of the people do you figure, if the proposal that you have introduced, would be able to benefit in terms of, say, hospital visits or days in the hospitals—how much would it be able to touch the lives of the unemployed?

Senator SPECTER. Senator Kennedy, I cannot give you a precise figure, but I think it would solve the emergency which exists at the present time. I am always at a loss as to how we project the statistics on the unemployed and the total dollar figure and the funds, as to how far it would stretch. I start from a limited approach, and I would pick up the figure of \$500 million, which is the figure that David Stockman used. And I would apply that as far as it would go on the practical approach that the greater importance is to get it started now and to see how it works and to come back for a supplemental.

Senator KENNEDY. That is about \$30 per person for the 18 million workers and their dependents that do not have some health insurance. I agree that just because we cannot solve all the problem that does not mean that we should not start trying to solve some of the problem. But I also think that we have some responsibility, and if we think that we are going to be dealing with the problem, that we not pass something inadequate and then also lead people to believe that we are really making much of a dent in it.

Senator SPECTER. Senator Kennedy, I do not believe that we are going to be directing our attention to 18 million families in this legislation.

Senator KENNEDY. Individuals—excuse me.

Senator SPECTER. Well, we are talking about somewhere in the range, as Senator Metzenbaum pointed out, of 11 million unemployed. I have seen a variety of figures, for example, of 90 percent, which would talk about something in the range of 9 million. The Pennsylvania statistics, which have been provided by the State, suggest to us, as outlined in my statement, that there are almost 400,000 who would be covered, which is less than a 90-percent figure. It may project across the Nation on a wide basis, something in the range of 6 million. It is hard to put a finger on the precise number, and I would like to approach it in a comprehensive way at this time. But if we are looking at the reality of a potential presidential veto, then my preference would be to take \$500 million, to start now, to see how far it goes, and to work on a supplemental.

Some of what David Stockman has testified to would be helpful in the future. For example, he wants to write into the tax laws a requirement that where a family has two or more wage earners incorporated in health plans that, should one become unemployed, the plan of the one who continues in employment would pick up the family. I think that is a helpful approach.

So there are ways to narrow the range of governmental costs, which I think do make sense.

Senator KENNEDY. Maybe we can work together to arrive at a common base, because even under the Stockman program, that only picks up 1.3 million persons under that particular definition. And if you take the 11 million people unemployed, and you figure 2.5 members per family, we are not only talking about the unemployed person, we are talking about coverage for the children in these families. We are talking about a significantly higher figure. I do think we should be able to get a common basis on numbers, both in terms of what the needs are and what amount of money and resources will be available and be spent.

But whether it is veto or nonveto, I think we have a responsibility to address the issue, and I would hope—and I am sure it is the Senator from Pennsylvania's view—that we will not just pass something that looks like we tried to address the issue, but not really have some impact on it, I know that is his view.

And I just want to thank the Senator from Pennsylvania for the leadership that he has shown on this issue and indicate a desire to work with him. I hope we can get some common understanding, about the magnitude of the need we can move from there.

Senator SPECTER. Senator Kennedy, I share that objective totally. Mr. Stockman testified about coverage of some 2.4 million, and I believe that it was 2.4 million of the unemployed, which would be a larger multiplier factor considering the families. But I agree with you that we should work together to define the area of problem and to define how far the resources would go, and then to push as hard as we can to get it done.

Senator Heinz and I were not unmindful of the fact that if two Republicans came forward from a State like Pennsylvania, which has the unemployment rate that we do, that we might have a little better chance of getting some attention from the White House, and I think we did get it. And when Senator Dole joined in, and Senator Quayle, and Senator Hatch, and Senator Durenberger, that is only a beginning effort. It ought to be a bipartisan effort. There have been major initiatives on both sides of the political aisle, and I think it is far above politics, and we ought to work together and define our terms and get it done.

Senator KENNEDY. Very fine. I thank you.

Senator QUAYLE. Thank you very much, Senator. As we go along here, I am sure that we will be working with you and your staff as we proceed.

Senator SPECTER. Thank you very much.

Senator QUAYLE. The first panel, from the American Medical Association, Dr. Sammons; from the American Hospital Association, Mr. Epstein; from the American Academy of Pediatrics, Dr. Cooper; and from the American Nurses' Association, Ms. Badura.

Dr. Sammons, welcome. You are first on the list, so go ahead.

STATEMENT OF JAMES H. SAMMONS, M.D., EXECUTIVE VICE PRESIDENT, AMERICAN MEDICAL ASSOCIATION, CHICAGO, ILL.; RICHARD L. EPSTEIN, SENIOR VICE PRESIDENT, AMERICAN HOSPITAL ASSOCIATION, CHICAGO, ILL.; DR. LOUIS COOPER, CHAIRMAN, CHAPTER III, AMERICAN ACADEMY OF PEDIATRICS, NEW YORK, N.Y.; AND MARIBETH BADURA, CLINICAL NURSE SPECIALIST, AMERICAN NURSES' ASSOCIATION, CHICAGO, ILL.

Dr. SAMMONS. Thank you, Mr. Chairman, and good morning to you and the other members of the committee.

Senator KENNEDY. First of all, Mr. Chairman, could I welcome our friends here? It has been a long time.

Dr. SAMMONS. Certainly. I have looked forward to this. You and I have not had the pleasure for some time.

Senator KENNEDY. We have had many hours together in this field.

Dr. SAMMONS. We have, indeed. This time, though, we are going to be on the same side.

Senator KENNEDY. Well, let's find out. Let's try. [Laughter.]

Senator QUAYLE. Thank you, Chairman Kennedy. [Laughter.]

Dr. SAMMONS. Mr. Chairman, the American Medical Association joins with the other members who have addressed you this morning in congratulating you on holding these hearings. It is our view that this is an acute problem in this country. It is indeed our view that the time has come when some action must be taken to alleviate this problem. It is also our view that there is a Federal role, that there should be a Federal role, and that the program will not, in fact, succeed unless there is a Federal role.

Having said that, let me hasten to add, however, that we are very proud of the fact that over 70 percent of the doctors in this country are providing health care to the unemployed at this moment in time on a markedly reduced rate or for free, and that 10 percent of the doctors in this country are actively involved in organized programs to provide totally free care to the unemployed.

That, however, is not sufficient at this moment, and we believe that the time has come for a limited program. It is our belief that this program would better be inaugurated using the unemployment compensation system. It is our belief that the continuity of care by virtue of State pools, the use of vouchers, or some other mechanism by the unemployed to obtain that coverage, with clearly specified benefits, and specific limitation of the program with review by the Congress at stated intervals, is an appropriate way to go.

We believe that the benefits that this program provides should be secondary to other benefits that the family may have. We believe that there should be some means-type formula for individual participation. Many program supporters, including sponsors of legislation, do in fact talk about the sharing of premium cost, and we believe that is appropriate. We think that in those instances where other members of the family, one or more, may be employed, that it is possible that the insurance protection given that individual might be extended to cover the entire family, including those members of the family who are unemployed.

We believe that a Federal contribution on a formula, taking into account the specific needs of the States and the fiscal position of those States, can be worked out and should be worked out by the Congress. We believe that there should be an encouragement to employers to extend timewise the present employee benefits, perhaps considerably beyond where they are today, in most instances. However, I think we have to recognize that there are some limitations when employers are faced with that entire load, particularly since some of the benefit programs negotiated in recent years might be called Cadillac-oriented, if you will, although such extensive benefits ought not be necessary to protect the needs of the people in this country at the moment who are unemployed.

We share with the members of this committee and the Senate Finance Committee, with Congressman Waxman's committee—with the entire Congress—our concern that medical care must be furnished to pregnant mothers, including prepartum, delivery, and postpartum care, as well as to the children of the families that are presently suffering through this unemployment condition in our

country. We believe that emergency care, physician office care, nonhospital outpatient care, the kind of services that are the most cost-effective methods of delivering care in this country, should be included in the program that the Congress might enact. And I have no doubt in my own mind that this Congress is going to act, and it is our belief that it is appropriate that you do act.

I will not use the rest of the time, Senator. I would ask only that our entire statement be placed in the record. I realize you have a long witness list. We will be happy to answer questions at the appropriate time.

And I extend to you a very sincere offer. The best offices of the American Medical Association are at the disposal of this committee or any other committee of the Congress of the United States in addressing this issue. We will be happy to work with you and your staff in any manner that will be productive.

Thank you very much.

[The prepared statement of Dr. Sammons follows:]

STATEMENT
of the
AMERICAN MEDICAL ASSOCIATION
to the

Subcommittee on Employment and Productivity
Committee on Labor and Human Resources
United States Senate

Presented by
James H. Sammons, M.D.

RE: Health Care and Health Insurance
for the Unemployed

May 3, 1983

Mr. Chairman and Members of the Subcommittee:

I am James H. Sammons, M.D., Executive Vice-President of the American Medical Association. Accompanying me is Harry N. Peterson, Director of AMA's Division of Legislative Activities.

The American Medical Association appreciates the opportunity to appear today to discuss the subject of health care and health insurance for the unemployed. We commend this Subcommittee for holding these hearings to highlight this important subject and to seek resolution of a serious problem facing the nation.

The problem of health care and health insurance coverage for the unemployed is not new. The United States has not achieved full employment for decades, and there has been a substantial level of unemployment among Americans over this time. In fact, this is not the first time that this issue has been addressed by the Congress. In 1975, with national unemployment in the 8% range, legislation was introduced and major hearings were held on this very same subject. The American Medical Association at that time endorsed federal efforts for a short-term program to provide health benefit coverage for the unemployed. What is new, Mr. Chairman, are the high levels of unemployment facing the nation as a whole and in specific areas of the country where unemployment nearly doubles the national rate.

Furthermore, knowledgeable analysts indicate the average length of unemployment during this recession has increased and that it is expected that a significant number of individuals will not be able to return to their previous jobs even during a national economic upturn. This extended unemployment problem has been recognized by the Congress through major extensions in coverage for unemployment compensation, including the recent extension of emergency benefits as part of the Social Security reform package. It has been estimated that some 5.3 million individuals have lost their jobs and their health insurance coverage. Thus there are millions who face the loss of medical care coverage for themselves and their families--including their children who need regular medical supervision. Furthermore, recent studies indicate that the unemployed are often in need of more medical care due

to the stress of unemployment. Mr. Chairman, we face a public health problem that must be addressed.

The effect of these economic circumstances can be widespread. During such times families must defer health expenditures, and they live in fear of incurring health expenses which may leave them in debt for an extended future period. Health care institutions are also affected and can be placed in serious fiscal jeopardy. Health insurance plans, faced with loss of membership, are less able to spread risks. There is an increasing impact across the entire health industry.

The current "crisis" relating to health insurance for the unemployed is a direct result of a very successful public policy that has encouraged employment-based health benefit plans. Approximately 90% of the non-farm U.S. workers receive health benefit plans through employer-based group policies, with their employer paying part or all of the premium. Therefore, when unemployment grows, the number of individuals who lose health insurance coverage increases.

Existing federal programs, including Medicare and Medicaid, provide specific health care benefits to targeted populations. State and local programs often provide health care services or coverage to those who do not qualify for federal programs, such as Medicare and Medicaid, but generally such assistance is limited to those who are without assets or other financial means.

The newly unemployed person rarely fits into one of these categories. When income from active employment ends, these individuals usually have significant assets, such as homes, cars and furnishings,

that preclude their participation in either Medicaid or state and local general assistance programs. Unfortunately, because of their loss of income and because of the higher cost of individual health insurance policies compared to group benefit plans, many unemployed individuals cannot afford to cover adequately the expected health insurance needs of their families. It is this group, then, that needs to be addressed. It is for this group that a bridge should be built to provide coverage for an interim period until the individual can become employed again and receive employment-based health insurance benefits.

For some time the AMA has been active in encouraging individual physicians, state and local medical societies, and national medical specialty societies to develop voluntary programs to ensure continuation of health care to the unemployed and their families who are in need of such care. Many physicians have assisted unemployed patients in meeting their health care needs. Seventy-nine percent of physicians surveyed by the AMA's Socioeconomic Monitoring System indicated that during October and November of 1982 they had treated patients who had lost their health insurance due to unemployment. Of those physicians treating patients who lost benefits due to unemployment, 71% provided care without charge or at reduced rates. Furthermore, at that time approximately 10% of all physicians were donating their services to some type of "fair share" program organized by community leaders and medical societies to provide services for those who have lost their primary source of income and do not qualify for government assistance.

Recent information indicates medical societies and the health community have become more active in initiating programs to assist the unemployed. To date we have catalogued 23 formal programs sponsored by medical societies or hospital medical staffs to assist the unemployed in receiving medical care. For example, as early as June 1981, the Wayne County Medical Society in Detroit, Michigan, began recruiting physicians to participate in a task force to ensure the availability of health care services for the recently unemployed. This program covers physicians from Detroit and Oakland County, which are especially hard hit by layoffs in the auto industry. Another example is the Harris County Medical Society in Houston, Texas, which has a program under which physicians provide free care in their offices or work in a public clinic for a day. This program has the participation of over 1000 of the Society's members.

We are proud of these initiatives and are encouraging more and more societies and physicians to follow suit. However, the scope of the current unemployment problem and the length of the current recession indicate to us that a temporary nationwide program to provide health insurance for the unemployed is necessary. This is especially true in light of the structural unemployment problems now facing the nation.

Mr. Chairman, as during the 1975 recession, a number of bills have been introduced in Congress to provide health benefit coverage for the unemployed. These bills embrace a variety of approaches. Our Council on Legislation is now reviewing the various proposals, and we expect to have a more definitive response shortly. Nevertheless, it is appropriate to

discuss options that are open to us as a nation. Governments at all levels are already financially strapped. A national program must not be self-defeating, i.e., it should not so increase the deficit structure as to impede economic recovery. The country's main objective must remain a return to a healthy economic condition. This is the main problem facing the unemployed. Together, however, we must find answers to a very real and serious problem affecting a significant number of our population.

Mr. Chairman, the AMA supports the creation of a formal program to provide health insurance coverage for the unemployed. In our view such a program should be based on certain basic principles:

It should have limited eligibility, targeted among the unemployed.

While government must have a role, the program should be administered in the private sector, providing private insurance coverage.

It should avoid disruption in continuity of care for the individual and his or her family and, to the extent possible, in continuity of health insurance coverage.

Financing should be a shared responsibility of government and the private sector.

It should provide benefits limited in scope, and provide for freedom of choice of providers.

It should be temporary and subject to early and ongoing Congressional and public review and evaluation.

I will discuss these areas in more detail.

Eligibility

Eligibility for such a program must be limited in scope. For quick adaptation it could be tied to some existing fixed standard, e.g., embracing those individuals who have had employment-based coverage and who have a right to receive regular, extended or federal supplemental unemployment compensation benefits. For ease in identification, the state unemployment compensation system could be used to identify qualifying individuals.

There is no need to cover certain individuals even though they are unemployed. Individuals should be excluded if coverage can be obtained by another family member who is eligible for employment-based coverage or is eligible for continuation of an employer-offered health benefit plan. In addition, persons who are eligible for Medicare, Medicaid, or other government programs should be required to use such coverage. Stating this more generally, the new benefit should be secondary to other coverage.

Equitable coverage within restricted available financing will be difficult to achieve, but must remain our goal. To achieve this more equitable coverage, individuals whose unemployment compensation benefits have expired should be grandfathered in. Nevertheless, some period limiting eligibility will need to be fixed.

Administration

A plan could be operated at the state level through the use of statewide insurance pooling arrangements or through the purchase of a policy by the unemployed individual using a voucher. All insurers,

including the self-insured companies, would participate. Again, a state unemployment compensation office could be used as the focus for identification of eligibility and for the individual to receive information and assistance in obtaining coverage. Private insurance must be the vehicle for benefit coverage. This new program must not become enmeshed with Medicare or Medicaid. Caution must be expressed lest new troubles be created through expansion of an entitlement concept.

Financing

Payment for the coverage could come from varied sources. Unemployed individuals should be responsible for some portion of the cost of coverage and care up to a maximum amount or fixed percentage of income. This could be accomplished by adjusting the individual premium obligation to reflect family income and through income-related coinsurance, deductibles and stop-loss levels. The federal government should share in a program that is to have viability. Particularly where national unemployment exceeds a certain level and a state's unemployment rate exceeds a figure, say 110% of the national average, the federal government should contribute to the program. This federal contribution would assist those states that are hardest hit by long-term unemployment. Employers should participate as well. The basic principle of unemployment compensation has worked well, and employers' contributions for health benefits through expansion of this system should be explored. Assistance to states through a block grant could provide federal assistance with flexibility in state management. Methods should be considered to encourage employers and those who are employed to extend employment based coverage in the event of lay-offs.

Benefits

If a program is to be viable, the benefit package must be keyed to financial feasibility. The premium must be reasonable in amount. Accordingly, the benefits must be limited. Nevertheless they should include critical services, such as inpatient hospital care, emergency outpatient hospital services, physicians' services, emphasizing outpatient services in a physician's office. Prenatal, maternity and postpartum care, as well as diagnostic, laboratory and radiology services, must be included.

Duration

In our view, any program created should be temporary. It should remain in place for a limited period of time with a sunset provision. Such a requirement would establish the need for Congress and the nation to reevaluate the continuation of or modifications to the program on a regular basis rather than creating another "untouchable" entitlement program.

Conclusion

Mr. Chairman, the American Medical Association has been actively involved in encouraging our members and other medical societies to provide health care for the unemployed. These activities will continue. However, the scope of the problem, along with the expected duration of high levels of unemployment, indicate a need for a more formal and comprehensive way of dealing with this temporary situation. We urge the Subcommittee to structure any program to encourage the use of the private

sector, both in insurance underwriting and service delivery. Use of the private sector will avoid disruption of existing relationships among patients, physicians, insurers and providers, thereby allowing for continuity of high quality care for families during the temporary period when an individual is unemployed.

We recognize the many problems facing this Subcommittee as it considers this subject. We will continue our analysis of the various legislative approaches before the Congress and will be pleased to offer our assistance in seeking an appropriate resolution of this serious problem.

Mr. Chairman, I would be pleased to answer any questions the Subcommittee may have.

Senator QUAYLE. Thank you very much. We have had a very good working relationship in the past, and we will accept your offer for continued endeavors and cooperation.

Thank you.

Mr. Epstein.

Mr. EPSTEIN. Good morning, Mr. Chairman, and members of the committee.

I would like to join the AMA in commending the chairman and the subcommittee for addressing this issue. We are pleased to have the opportunity to amplify on our statement that was submitted earlier to the members of the committee.

It is obvious to all of us here that based on the remarks and statements that have been made at other hearings and this morning, that the concern expressed for the unemployed is shared and that it is indeed bipartisan. But at some point, it may be too easy to assume a Federal role is appropriate and helpful, or it may be too easy to lose sight of the special role that the Federal Government has in addressing this problem.

I would like to use my few minutes, Mr. Chairman, to amplify on the prepared statement that we gave you, to describe the five reasons why we think Federal funding is necessary and indeed appropriate for this undertaking.

The five reasons are these. We believe that Federal funding, that is Federal participation through funding, would first serve as a catalyst in order to motivate and provide incentives, for community efforts. Second, we believe that Federal funding would serve as a cushion to those who are hardest hit by this problem.

One important characteristic of this problem is not one of access to needed care, but in how you distribute the cost implications of such care. It is important that this distribution, in order to be done effectively, must include various groups in a community that have

anything to do with the delivery of health care, the payment of health care, the quality of health care, so that responsibility may be shared equally.

A fine way to do it is at the community level, but this needs to be done by having the States participate, and this can be enhanced by having Federal funds available to encourage it.

The third reason for Federal support is to look at this in terms of the savings that can be achieved, by making sure that care is available early in the treatment period. Too many persons who are caught in this dilemma are too proud to ask for aid and too poor to be able to purchase it, and therefore go without preventive care. Prenatal care, which has been referred to several times this morning, is an eloquent example of that kind of problem. And so, the expenditures that would be incurred here would result, really, in savings to our society.

The fourth reason is to avoid the consequences of failure to address this at the national level, by virtue, really, Mr. Chairman, of the irony or incongruity of ignoring the other matters of concern on our national agenda. I speak here of our national concern about the rate of crime, about our national concern about child abuse, about our national concern about handicapped newborns, about our national concern about encouraging savings and investments on the part of all people, and our concern that these resources not be used up in the devastation that may hit one family which has not been able to pay for care.

The fifth reason for supporting Federal efforts in this area is the opportunity for States to experiment in providing needed care. The Federal Government has not engaged in this kind of participation in this kind of issue heretofore, but there are a number of mechanisms that may be used, and used successfully, depending upon the State, depending upon the community, such as insurance pooling, such as capitation, and States need to have the wherewithal to experiment so that the programs that provide this kind of coverage will have been explored and will be effective and will be focused on solving the problems.

And the last is to encourage participation at the community level, because that is where the greatest sensitivity is, to the families and persons and industries that have been affected by this phenomenon.

And so the incentive is at the community level. The communities need the States to assist them, and this is an appropriate role for the Federal Government.

Mr. Chairman, we have prepared comments that I would like to submit, which cover various other points that have been referred to and which expand on the position of the American Hospital Association.

Senator QUAYLE. Thank you. The entire statement will be inserted in the record.

[The prepared statement of the American Hospital Association follows:]

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STATEMENT OF THE AMERICAN HOSPITAL ASSOCIATION
TO THE SENATE SUBCOMMITTEE ON EMPLOYMENT AND PRODUCTIVITY
COMMITTEE ON LABOR AND HUMAN RESOURCES
ON
HEALTH INSURANCE COVERAGE FOR JOBLESS WORKERS

May 3, 1983

The American Hospital Association, on behalf of its 6,300 institutional and 30,000 personal members, is pleased to present its views on health insurance coverage for unemployed workers. This issue is one of priority interest to health care providers, as well as many others in the private and public sectors who have faced the problem of assuring continuity of community health care during the recent period of sustained high unemployment.

The AHA commends the efforts of this Subcommittee and other Committee's in Congress to provide some form of assistance to those who have lost job-related health insurance benefits. But we believe the need for federal assistance is urgent. We hope that both Senate Committees looking into this problem will agree on a unified, bipartisan approach soon and move Congress quickly to provide a program for state and community private sector assistance to unemployed workers and their families who are in need of health care coverage.

At the present time, many communities, hospitals, physicians, insurers, business, and labor organizations are making special efforts to meet the needs of this population group. State and local governments also have joined or supported these voluntary initiatives in many instances. The point we would emphasize is that federal legislative efforts should build on and support local initiatives already in place, ensuring that federal programs do not displace private-sector and state and local government programs.

Nature and Significance of the Problem

Approximately 12.4 million Americans, or more than 10 percent of the labor force, currently are unemployed. Even with improving economic conditions, high levels of unemployment are expected to continue for several years. The Congressional Budget Office (CBO) indicates, for example, that unemployment rates will exceed 9 percent through 1985. With over 90 percent of the private, non-farm labor force receiving health insurance benefits through employment, the great majority of the unemployed--an estimated 14 million to 21 million individuals, according to CBO--are without health insurance protection.

For most of the unemployed, the question is not one of access to health care services but the cost of such care. Many who formerly purchased coverage for themselves and their families no longer are financially able to do so. They allot limited resources to other necessities such as food, shelter, and clothing. In addition, loss of employment means a loss of eligibility for

group insurance rates and employer contributions. According to Alexander and Alexander's Human Resources Management Groups, the annual premium for the worker who converts from group coverage to individual coverage averages \$1,200 to \$1,800 a year. An unemployed individual receiving unemployment insurance benefits surely cannot afford such coverage.

It should be noted that, within the broader issue posed by loss of employment-related health benefits, there are two separate problems. The first pertains to the "temporarily" unemployed, persons for whom there is a reasonable prospect of regaining employment-related health benefits as the economy recovers. For these persons, public and private actions can provide effective interim means to assure continuance of needed health services. The second problem pertains to the "structurally" unemployed, persons who are unlikely to be rehired because of fundamental economic problems in a particular industry. Assuring availability of health care (and other necessities) for these persons is likely to require a longer-term response in the form of economic assistance and employment retraining.

For either group, health problems could be substantial and are cause for concern. Many unemployed workers, for example, are postponing needed medical care because of lost health insurance. That circumstance, particularly with regard to preventive, prenatal, and post-partum services, ultimately will cause more severe and costlier health problems in the future. We fear that the incidence of stress-related illnesses among the unemployed is already on the rise, and infant mortality rates, especially in high-unemployment

communities, have increased. In Michigan, the state with the highest unemployment rate in the country, the infant death rate rose 3 percent from 1980 to 1981--from 12.8 deaths to 13.2 deaths per 1,000 live births. In the same period, the national rate declined by 6.4 percent, to 11.6 deaths per 1,000 live births.

Hospitals and other health care providers share the nation's concern over such setbacks in community health. We regard the human suffering that has resulted as intolerable and foresee long-term effects on community health resources. In the face of high interest rates and general economic pressures, coupled with substantial reductions in payment levels under Medicaid and other federal programs, hospitals and physicians have limited resources with which to respond to a growing population of under-insured and uninsured. Rising levels of bad debts and charity care, which are not recognized by Medicare and Medicaid, are threatening the financial viability of some providers.

Generally, hospitals that traditionally have provided substantial services to the publicly sponsored and indigent populations in their communities bear an inordinate share of the problem. A study conducted jointly by AHA and the Urban Institute--a survey of 453 hospitals of which 13.3 percent were public facilities--indicates that large public hospitals averaged about \$32.8 million in free care to the poor, compared with \$16.8 million for small public hospitals, \$9.5 million for large private hospitals, and \$3.4 million for small private hospitals.

The situation presages a significant long-term problem of gradual but substantial erosion of health resources in economically depressed communities, particularly inner-city areas. It will be difficult and costly to restore these lost resources, even with substantial improvement in the economy.

Recommendations

The AHA strongly supports creation of a federal program designed to assist insurers and providers of health care to continue providing quality care to displaced workers and their families. The public and private sectors must share responsibility for these workers equally; federal efforts should not displace this responsibility nor act as a disincentive for innovative private-sector approaches. Federal legislation must be flexible and should encourage state and local governments in partnership with the private sector to target aid quickly and efficiently to communities with the greatest need. We believe that federal legislation should adhere to the following general guidelines:

- o Public and private sector responsibility: Federal efforts should not create a regulatory structure that will act as a substitute for creative state and local government or private sector initiatives, but instead act to complement efforts already underway.
- o Flexibility: States should be encouraged to develop programs that target aid quickly and efficiently to communities with the greatest need. For

example, Capitation arrangements between state and local governments and providers of health care services should be encouraged.

- o Eligibility: States should seek to cover as many unemployed workers and their dependants as financially feasible and should limit the program to "payer of last resort."
- o Beneficiary contribution: States should be given the option to require premium contributions and cost-sharing by beneficiaries. These payments should be modest, however, and not become a disincentive to health care coverage.
- o Means test: Means testing should not be required as a condition for eligibility. The program should provide health care support to workers and their families unable to afford such coverage; it should not be structured as a welfare program.
- o Benefits: The program should encourage coverage of preventive services, especially among young children; prenatal and post-partum care; and limited inpatient and outpatient emergency hospital care. It also should contain a catastrophic illness component.
- o "Sunset" provision: A "sunset" provision is essential to encourage on-going Congressional and public review of the program. Must avoid setting up a mechanism which encumbers states with long term obligations for which they lack adequate resources.

S.811

S.811, introduced by Senator Specter for himself and Senator Heinz, would establish a grant program to assist states in structuring health benefits to cover eligible unemployed workers and their family members. To be eligible for coverage under S.811, a worker would have to be either collecting or entitled to regular, extended, or supplemental unemployment compensation coverage or receiving or eligible for such compensation within the last year. Funds would be allocated to states as provided in Section 301 of the Job Training and Partnership Act. States would have to file an application with the Secretary, which would include assurances that they would comply with the conditions set forth in the bill: public hearings, outreach activities, and coordination with existing programs. A one-percent limit would be placed on administrative costs. The program would authorize expenditures not to exceed \$1 billion in fiscal years 1984, 1985, and 1986.

In general, AHA would support strengthening S.811 to include several of the general legislative guidelines discussed earlier. We believe that eligibility requirements must be clearly set forth in the bill and, if financially possible, should "reach back" at least two years. AHA would also encourage the Committee to include a minimum benefit package to ensure adequate coverage and would support inclusion of a provision which would, at the state option, allow minimum premium and copayment requirements. We also believe that states should have the option to waive these requirements on a case-by-case basis.

S.1154

S.1154, introduced by Senator Kennedy for himself and several other members of the Labor and Human Resources Committee, also authorizes a grant program to assist states in developing programs which provide health care coverage for displaced workers. Funds would be allotted by a formula that would take into account unemployment rates and the extent of long-term unemployment. States experiencing unemployment rates exceeding 10 percent would not be required to match federal funds; states experiencing unemployment rates of less than 10 percent would be required to match payments at declining rates.

S.1154 would leave a great deal of flexibility to states in designing the program; however, several requirements would have to be met for states to qualify for federal assistance. These requirements include coverage for workers now receiving or entitled to receive regular, extended, or supplemental unemployment compensation coverage or workers who had been receiving or were eligible to receive such coverage during the past two years. States would also have to establish benefit packages which include but are not limited to inpatient and outpatient care; primary and preventive services; and pre-natal, delivery, and post-partum care; and set limits on premium contributions and copayment requirements.

S.1154 authorizes the expenditure of \$900 million in Fiscal Year 1983 and \$2.7 billion in FYs 1984 through 1986. The bill also provides for a special grant program to public and nonprofit health care providers authorized at \$100 million for FY 1984, \$110 million for FY 1985, and \$120 million for FY 1986.

AHA supports the intent and general outline of S.1154. It provides sufficient flexibility for states to continue ongoing efforts while encouraging the development of new, innovative, and more comprehensive approaches.

The specific provisions contained in S.1154 regarding benefits, copayments, premiums, and matching requirements are important and appropriate. AHA supports these provisions and, in addition, would encourage the Senator and the Subcommittee to review the feasibility of including catastrophic illness coverage. AHA also strongly endorses the direct grant program for public and nonprofit hospitals that have for many years served a disproportionate number of charity care and indigent patients.

AHA is, however, concerned with Section 2104 (b)(11), which gives preference to health maintenance organizations that offer health benefit packages comparable to or costing less than other programs. Because we fully support the notion of flexibility and equal access for all providers, we fear that this provision, if not clarified, will tie the hands of state governments trying to offer comprehensive, statewide coverage. HMOs offer one alternative for coverage and should not be given exclusive rights over other providers.

Conclusion

Again, we commend the efforts of all the committees in Congress looking into the problems of health care coverage for unemployed workers. AHA believes that the need for federal assistance is urgent but that any program must be

flexible to encourage and support development of private-sector initiatives. AHA believes that state and local governments, with the cooperation of local employers, labor unions, and health care providers, should be allowed to choose among various approaches--state insurance pools, Medicaid, capitation, or vouchers--in order to serve the health care needs of this population group.

We stand ready to assist the Subcommittee and lend our support to those efforts.

Dr. Cooper.

Dr. COOPER. Thank you, Senator Quayle, for holding these important hearings, and I want to thank all of the Senators for their very sensitive and insightful comments about the nature of the problem, a problem that we see on the firing line every day and that obviously, you appreciate, even though you do not have to spend your day delivering health care to needy people. We appreciate it very much.

I am director of pediatrics at St. Luke's Roosevelt Hospital Center, and professor of pediatrics at Columbia University. Our voluntary hospital has almost half a million clinic visits a year. But I speak on behalf of the 24,000 pediatricians, members of the American Academy of Pediatrics, and our president, Dr. James Strain, is here with me today.

It would be wasteful and redundant to review with you the geographics and demographics of unemployment or of the appropriation national preoccupation with cost containment in our health industry, but I will focus on the special needs of kids.

Parents are disproportionately young, are the most recently hired, the first to be laid off, and have the least reserves to fall back on. This is especially true for adolescents and for young, pregnant women. Infants and children are particularly vulnerable. Even when the economy has been more favorable, a huge gap exists between national beliefs and reality. This gap is unlikely to be closed until there is a more general understanding that children's health needs are different and are amenable to different techniques and tools, and yet children have been denied access to these techniques and tools out of a serious pattern of discrimination, which is unintended and understandable only in historical perspective. It ignores all that we have learned about the value of preventive and early treatment services and continuity of care.

Unfortunately, like all bad habits, this one will require a long time to correct. This longstanding discrimination, however, sets the stage for the special crisis which precipitated these hearings. The most effective care is personal, continuous, comprehensive, and integrated, primary care, as you know. This primary care for kids emphasizes prevention, through medical tools such as immunization; parent competency--building techniques, such as anticipatory guidance and counseling on safety, nutrition, current management of learning and behavior, and early recognition of when, where and

how to seek medical care. This latter skill, in my varied experience, makes a huge difference when kids get sick, both in the success of treatment, in diagnosis and treatment, and in the cost of illness management. These preventive and early treatment features of primary care should be cornerstones of our national child health effort. They are seriously weakened by unemployment and underemployment.

Pediatricians give free care every day and always have, and in a number of communities they are attempting innovative efforts to address the current problem. But they are unable to address the task. No one worthy of the label of "physician" could turn away a sick child, and no hospital would dare ignore an acutely ill young patient. If time permits, I will return to the consequences of giving such care in certain, hard-pressed areas.

The single most important barrier to primary care for kids and pregnant women is out-of-pocket cost. We were all shocked that as recently as 1981, HHS showed that one-third to one-half to one-quarter of our kids were underimmunized. Recent efforts have improved that, but immunization rates are a good measure of primary care. Even in reasonable economic times, young families with little disposable income tend to defer preventive care and feel pressures to ride out or wait and see when a kid is sick. You can imagine how much that has been increased by the problems of underemployment and unemployment, and that is what we see all the time.

Furthermore, less than 30 percent of private health insurance pays for out-of-pocket visits to kids. So, what is happening? People are delaying care, they are delaying preventive care. And what should we do? The academy has developed a set of principles of child health financing, which we will include with written testimony, and I will be happy to add more detail, if time permits, of what we are seeing every day, of the impact of the unemployment and underemployment on health care of kids.

Thank you.

[The prepared statement of Dr. Cooper follows:]

**PREPARED STATEMENT OF LOUIS Z. COOPER, M.D., F.A.A.P., ON HEALTH INSURANCE
FOR THE UNEMPLOYED**

Thank you for inviting me to talk with you on the important subject of health insurance for the unemployed. I am Louis Z. Cooper, director of pediatrics at the St. Luke's Roosevelt Hospital Center and professor of pediatrics at the College of Physicians and Surgeons of Columbia University. I serve as chairman of New York Chapter 3, American Academy of Pediatrics, and as a member of the Academy's national Committee on Child Health Financing. I speak, therefore, primarily from personal experience in New York, but also with the concerns of more than 24,000 members of the Academy for needy children and their parents across the United States.

It would be wasteful and redundant to review with you the geographics and demographics of unemployment in the United States -- or to belabor the appropriate national preoccupation with cost containment in health industry. I will focus instead on the special problems of children and pregnant women which have been exacerbated by unemployment across the nation. Many factors make pregnant women and children particularly sensitive victims of unemployment. Parents are disproportionately young, the most recently hired and generally the first to be laid off. They have the least financial reserves to fall back on, and this is particularly true for adolescents and pregnant women.

Furthermore, infants and children are particularly vulnerable. Even when the economy has been more favorable, a huge gap has existed between national, honestly held beliefs and reality. This gap is unlikely to be closed until there is more general understanding that children's health needs are different and are amenable to different techniques and tools. It is well documented that children have been denied access to those techniques and tools out of a serious pattern of discrimination which is unintended and understandable only in its historical perspective. This discrimination ignores all that has been learned about how to keep children healthy, and is absolutely unacceptable to all of us who have had an opportunity to learn about the problem. Unfortunately, like all entrenched bad habits, the problem is one which is slow and difficult to correct. This longstanding discrimination sets the stage for the special crisis which has precipitated the need for these hearings.

The most effective care (and there is strong evidence that it is even the most economical) is personal, continuous, comprehensive and integrated. Such "primary care" for children emphasizes prevention through medical tools such as immunization and parent competency-building techniques such as anticipatory guidance and counseling on safety, nutrition, parent management of child learning and behavior and early recognition of when, where and how to seek medical care. When children get sick, this latter skill makes a huge difference in the success with which we diagnose and cure, and in the cost of illness management. These preventive and early treatment features of primary care should be the cornerstones of our national child health effort. They are seriously weakened by unemployment and underemployment.

Pediatricians give free care every day and always have. In a number of communities innovative efforts are being made to try to meet the current added problems. No one worthy of the label physician could turn away a sick child -- and no hospital would dare ignore an acutely ill young patient. However, the goal of pediatricians is to keep children well or to see illness early when it can be nipped in the bud; underemployment and underinsurance greatly weaken our ability to play a proper role in that area.

The single most important barrier to primary care for children and pregnant women is "out-of-pocket cost." We all were shocked that as recently as 1981 the National Center for Disease Control national immunization survey showed that one-quarter to one-third of our children were still underimmunized. Targeted efforts with your support and federal, state, local, public and private commitment have reduced that figure during the past year, but immunization is one very important indicator of access for primary care. As you know, no aspect of preventive health services is as well understood, generally accepted, easy to deliver and economical as immunization. In fact, it is the easiest component of a primary care program to maintain. Therefore, when immunization levels are inadequate, it is a sensitive and clear indicator that primary care is not reaching all of the children it should. (On the other hand, high immunization levels by themselves are not a reliable indicator that primary care is adequate and complete. That is because immunization can be accomplished in a fragmented way with little impact on all the other important preventive and early treatment services I mentioned previously.)

Even in reasonable economic times, young families with little disposable income tend to defer preventive care and feel pressures to "ride out or wait and see" when their children have early symptoms of illness. Many people do not realize that most preventive and early treatment care was "out of pocket" even before loss of benefits due to recent unemployment. For example, less than 30 percent of private health insurance pays for office visits for children and only 10 percent covers preventive pediatric care. Imagine the impact of unemployment on financial and emotional stress. Is it surprising that families in this stressful period put off taking their child to the doctor when he or she seems well? Preventing future problems pales in comparison with just getting through the day.

Parental pride is another barrier which prevents the unemployed and underemployed from seeking care. This is especially so for the recently unemployed who have had no experience in the past with the difficult task of accessing traditional public or free care.

What has happened to child health as a consequence of recent economic conditions? Definitive statistics are not yet available. You are familiar with the alarming reversal of the infant mortality trends in several hard-hit areas of unemployment such as Michigan. No such figures are available in New York City. However, you must remember that in New York City recent unemployment is "a snowflake on a snowball." Our chronically unemployed remain a most serious problem. How much the new unemployment has contributed to the dramatic increase in child abuse, which my own institution has experienced, cannot be quantified, but it seems reasonable to suspect that it has played an important role in family stress. To be specific, at the St. Luke's site there was a 50 percent increase in child abuse in 1982 over 1981, from 120 children to 180 children.

In New York City my colleagues and I also have isolated, anecdotal experience which is cause for alarm. Examples include the several children with a variant of sickle cell disease (SC disease) who fail to keep their regular appointments for preventive care because their parents lost their health insurance benefits as a result of unemployment. With this disease we know that serious complications can be prevented by a special immunization and recurrent transfusions.

When the patients don't come in, they don't get this care, and life-threatening complications can ensue.

Acute middle ear infection is an almost universal illness of early childhood. When treatment is inadequate, not only may there be acute complications of spread, but even more important, there may be subtle and progressive hearing loss. For that reason, we regularly ask parents to bring children back in for a reassessment after they have been placed on treatment for the acute infection. Parents are bringing their children into the emergency room for the acute, painful illness, which is usually accompanied by fever. They are failing to return for the proper checkups after treatment has been initiated. Only time will tell if this adds to our problem of hearing loss among children. You are quite aware of the impact of hearing loss on childhood learning.

Asthma is the most common reason for hospitalization among urban poor children in many institutions. Hospitalization, with all its acute and chronic hazards to the child and economic cost to the community, can be greatly reduced by proper preventive education and treatment programs. In our institution, we have seen a substantial drop in visits to our allergy clinic where this kind of care is provided. Since we do not turn away children with acute asthma, they continue to show up in great numbers in our emergency room and require hospitalization.

The reason our problem in New York City is so chronic is that although there are 600,000 children eligible for Medicaid in the city, 900,000 others are from families with incomes less than 150 percent of the poverty level. As you know, across the United States only approximately one half of the children from families with incomes below the poverty level are covered by Medicaid. These numbers help to emphasize how vulnerable young families are to the extra financial burden of recent unemployment.

As a pediatrician, I must mention availability of early and appropriate prenatal care. In a recent study in New York City it was documented that the neonatal mortality rate when mothers had no prenatal care but came to the hospital for the first time only to deliver was 10 times greater than the rate for women who had adequate prenatal care. When asked why they failed to seek earlier care, the reason given most frequently was inability to pay. Again, no hospital can fail to deliver a woman who presents at its doors in labor. It is the custom rather than the exception that hospitals do not require payment or evidence of ability to pay when women attempt to register early for prenatal care. It takes little imagination to appreciate what loss of health benefits may do to early seeking of prenatal care. Finally, a word about unemployment and its impact upon the individual physicians and the institutions that have traditionally provided care to the employed poor and the unemployed. As you know, the distribution of unemployment and poverty is spotty. The institutions that and doctors who have played a major role in serving the poor and working poor have been economically pressed for a number of years. As unemployment has increased, they are being asked to take on an even greater share of people who themselves cannot afford to pay for care. That must have direct and harmful effects on the quality of care which children and pregnant women receive. For example, in my own setting, we have had to reduce greatly our efforts at outreach prevention and attention to the less immediately life-threatening illnesses in order to insure 24-hour availability of care for the acutely sick child. It is hard to

escape the fact that if we do not pay for these preventive and early treatment services now, we will pay far more in human and economic terms later.

What role should the federal government play in responding to this immediate and more long-term crisis? Whatever solutions evolve, pediatricians are in agreement that barriers to appropriate primary care for all children must be removed. Proper primary care, with its emphasis on personal, preventive and early treatment services for children, give the medical community its best opportunity to insure a healthy next generation. Because of the heterogeneity of our children, families and communities within the United States, no single approach will meet the needs of all. Recently, the American Academy of Pediatrics developed two documents (enclosed): a statement of principles of child health financing, and a policy statement on Medicaid. We believe that these statements which reflect considerable work by pediatricians from across the United States may be helpful to you as you work through the difficult task of seeing that health care is not denied families because of our current unemployment crisis.

On behalf of the Academy, we appreciate your awareness of and sensitivity to these serious problems as evidenced by these hearings. We look forward to continuing to work with you and appreciate the urgency of the task.

Thank you.

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AMERICAN ACADEMY OF PEDIATRICS PRINCIPLES OF CHILD HEALTH CARE FINANCING

Whether it is through employment, personal means, a publicly financed plan or a privately purchased plan, the financing of health care must provide for appropriate pediatric care. An unacceptable level of mortality and morbidity persists today among American children, and it is clear that archaic and inequitable financing mechanisms contribute to this circumstance.

Waste, inefficiency and discrimination against children in current financing systems must give way to improvements which maximize access to comprehensive pediatric care and ensure the quality of that care.

As both the public and private sectors continue to explore the redesign of health financing, the following principles are among those against which the Academy will weigh proposed changes:

1. Children's Right to Access to the Health Care System
 - All children have a right to health care.
 - Financial barriers should not prevent children from receiving comprehensive health care.
 - When families are unable to provide for adequate health financing, through employment, purchase of a private plan, or personal means, children should be covered by a comprehensive public plan.
 - Health care financing systems should permit reasonable options for the patient to choose appropriate providers of services.
2. Standards for Comprehensiveness and Quality Assurance
 - Health care financing systems should cover medical care needed by infants, children, and adolescents, including prenatal consultations, newborn care, preventive care, health supervision and treatment services through age 21.
 - Health care financing systems should encourage continuity of care by primary care physicians.

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- . Health care financing systems should recognize the value of cognitive services in addition to procedural services.
- . Health care financing systems should cover physician-directed ancillary and rehabilitative services.
- . An appropriate mechanism for quality assurance must be incorporated into all child health financing systems. Such mechanisms must include adequate peer review.
- . All terms, provisions, and specifications of health financing plans and any limitation, exclusions or cut-offs must be stated in clear and simple language so as to be readily understood by all parties.

3. Standards for Cost-Containment

- . Cost-containment is essential, but must not impair the quality of care. Physicians must play an important role in this process.
- . Health care financing mechanisms should be flexible and pluralistic.
- . Financial incentives should be used to encourage systems which promote quality and efficiency.
- . Health care financing systems should encourage delivery of services in the setting that provides quality care at the lowest cost (e.g., physician offices versus emergency rooms).
- . Cost-sharing should not be applied to preventive and/or health supervision services.
- . Fair competition among health care financing mechanisms is desirable, provided that all competing plans assure access to quality care.
- . Regulations governing health care financing mechanisms must not impair access to or quality of care.

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MEDICAID POLICY STATEMENT

The American Academy of Pediatrics recognizes the achievements of the Medicaid program in reducing financial barriers to health care for poor children; however, the legislative intent of the program has yet to be fully achieved.

An administrative structure focused on ensuring access to acute care and long-term care has allowed vital preventive care for children to languish while program expenditures have soared.

A confusing tangle of eligibility requirements has eliminated many of the neediest children from program participation.

State discretion in covered services has resulted in major disparities among geographical areas, leaving many eligible children with inadequate care.

The American Academy of Pediatrics seeks to remedy this situation. The following specific proposals are the minimum provisions that the Medicaid program should include for its child beneficiaries.

I. Eligibility

- A. The sole determinant of program eligibility for children should be financial need. Categorical requirements, e.g., only children from single-parent families, should be eliminated from eligibility criteria.
- B. The means-test for children should include limits on readily disposable assets and an income standard equal to a fixed percentage of the federal poverty line, (at a minimum, 65%).
 1. The income standard could be adjusted to reflect geographical differences and should be recalculated annually to reflect changes in the federal poverty income standard.
 2. "Spend-down" provisions for children in families whose income before medical expenses exceed the eligibility limit, should be continued.

- C. Automatic eligibility of unborn and newborn children should be included as long as the child's family meets the means-test requirements.
- D. Outreach should be mandated in all states to inform potentially eligible children of the new eligibility standards.
- E. All of the above standards should be applied to all children through age 21.

II. Benefits

- A. The minimum package of benefits for children should include health supervision services, acute care services, chronic disease services, and catastrophic disease services utilized when indicated as medically necessary.

- 1. Specific services include all of the currently classified "mandatory services" and a majority of the currently classified "optional services."

- * Current Medicaid law defines the following as "mandatory services":

inpatient hospital services; outpatient hospital services; rural health clinic; laboratory and X-ray; skilled nursing facilities (SNF) for individuals age 21 and older; physicians' services; early and periodic screening, diagnosis and treatment (EPSDT); and family planning services.

- ** Recommended "optional services" include:

optometrists' services; other practitioners' services; private duty nursing; clinic services; dental services; physical therapy; occupational therapy; speech, hearing and language disorders; prescribed drugs; dentures; prosthetic devices; eyeglasses; diagnostic services; screening services; preventive services; rehabilitative services; intermediate care facilities (ICF) services; ICF for the mentally retarded; inpatient psychiatric services for under age 22; SNF for under age 22; emergency hospital services; and personal care services.

- B. Services currently provided by ESDs must be delivered by a continuing care provider, in a timely manner, using the American Academy of Pediatrics "Guidelines for Health Supervision" as the periodicity schedule.
- C. If Medicaid should become a fully federalized program, states with more comprehensive benefits than a federal minimum should be required to maintain those benefits, with the federal government continuing to share in these expenditures.

III. Financing

- A. Open-ended entitlement-type funding must be continued whether the program is financed from federal or federal and state funds.

IV. Administration

- A. Every one to five years, each state should develop a Children's Medicaid Action Plan that will define goals to be achieved, both in the delivery of health care to children and in outcome objectives.
- B. Each state should establish a Children's Medicaid Advisory Board, including members with recognized expertise in the medical/surgical care of children. This group shall evaluate the Children's Medicaid Action Plan and advise on: (1) standards of examination (frequency, content, etc.); (2) provider issues (facilitation of involvement, qualifications, performance evaluation); (3) state regulations (fee structure and claim forms); and it shall serve other necessary roles.
- C. States should be allowed continued flexibility in program structures as long as the minimum eligibility and benefits standards outlined in Sections I and II are maintained.
- D. Eligible recipients should be given reasonable options to choose appropriate providers of services.

- E. Financial incentives can be used to enroll eligible recipients in different delivery systems.
- F. Quality assurance in all delivery systems should be safeguarded by physicians with expertise in caring for children.
- G. Special attention should be paid to safeguard access and quality in prepaid delivery systems.
- H. Reporting burdens and claim form complexity should be minimized, but data should be uniformly collected so that the program can be periodically evaluated for the purpose of improving its efficiency and effectiveness. Age-specific data, diagnosis, and eligibility category should be included in addition to standard recipient identification information.
- I. Claims payment performance standards should be adopted to ensure prompt provider payment and minimize retroactive claims denials.

V. Provider Reimbursement

- A. The program should provide for adequate differentials for the special needs of children in all forms of reimbursement.
- B. Adequate reimbursement to office-based physicians should be provided to ensure participation of continuing care providers.
- C. Reimbursement mechanisms should be pluralistic.
- D. Experimentation with various methods of capitation payment should be encouraged.

VI. Cost Containment

- A. Cost containment is essential, but must not impair the quality of care.
- B. Preventive care for children through health supervision delivered by a continuing care provider is the best approach to containing costs.

- C. Copayments should not be applied to preventive care and health supervision services.
- D. Methods to reduce overutilization of services, e.g., second surgical opinions, hospital preadmission reviews, prohibition of non-emergency weekend hospital admissions, are encouraged as long as access to and quality of care are not sacrificed.
- E. The program should encourage delivery of services in the setting that provides quality care at the lowest cost, e.g., home health care rather than institutional care.
- F. Efforts should be made to contain costs by testing alternative reimbursement methods.
- G. States should be given financial incentives to minimize fraud and abuse by providers and recipients, and to recover funds from other liable third parties.

Senator QUAYLE. Thank you, Dr. Cooper.

Ms. Badura.

Ms. BADURA. Thank you very much, Senator Quayle.

I am Maribeth Badura, a pediatric clinical nurse specialist in Chicago, and a member of the American Nurses' Association. With me is Cindy Dittmaier from our ANA staff.

I am here testifying on behalf of the American Nurses' Association, and we welcome this opportunity to present our views on the problems of lack of health insurance coverage faced by the unemployed.

If you are unemployed in Illinois and you need health care, you have very few options open to you. For \$1,600 per year, a family may purchase a low-benefit, major medical health insurance plan, or perhaps, if you are a couple in your fifties, you can purchase the same plan for \$4,000 per year, or only \$335 per month. As of February 1, 1983, the option of access to health through the aid to medical indigent program was eliminated. As of July 1, the option of access to the general assistance program is targeted for elimination. Sources of health care through the free Public Health Department clinics are drying up.

Not all counties in Illinois have public health departments, and many of those counties that do have health departments do not offer comprehensive primary care. Even local public health clinics such as those in Chicago are now charging families up-front free of \$3 to \$15 per family member. When you are dealing with eating, paying rent and utilities, a visit to the clinic for the family can be the cost of the food for a week. Or, the choices can be heat or a roof over one's head, as it was for an unemployed clerk in Champaign. A diabetic, she could not scrimp up enough money to pay for her insulin. The home health nurses found her near death in a diabetic coma. She had stretched that last little bit of insulin too long.

From Cook County suburbs in Dixon and Chicago, we have mothers and their newborns being discharged from the hospital before the newborn is 48 hours old, because the family is unable to pay. Early discharge in low-risk situations is an advocated alternative in childbirth, if there are a series of protocols filed that require a community health nursing outreach and physician's visits within that first week alike. Unemployed families, however, cannot even afford the hospitalization, let alone the cost of this followup.

Last year, Chicago's public health nurses may have been available to provide this service free. Today, because of fiscal cutbacks by all levels of government, these nurses serve only 19 of Chicago's 76 community areas.

Yesterday, a newborn who received an early discharge from one of Chicago's teaching hospitals lay dying in the intensive care unit of Cook County as a result of a strangulated bowel. The family had taken home a seemingly healthy baby boy. His malrotated bowel was not yet apparent. The family failed to follow through on the required physician's visits because they could not pay for them.

In situations like this, the family's guilt is tremendous. Maybe they had waited too long before bringing him to the hospital. Yet how could they pay for another doctor's visit or another hospitalization when they had an outstanding hospital bill of about \$2,500 for his delivery still to pay?

Steven was 6 weeks old when he went home from the neonatal intensive care unit last week. He is a scrawny baby, who does not like to be cuddled, who fusses the entire time he is awake. Steven has sleep apnea or, as it is incorrectly termed, "near-miss sudden infant death syndrome." Steven's mother has been forced to return to work so that that family can purchase the low-option major medical health insurance offered by her firm in case Steven needs to be rehospitalized. On a secretary's salary, the monthly health insurance premium eats up one-sixth of the family's spendable income. An apnea monitor may cost an additional \$115 per month, and there are still the drugs and the other costs of baby care. Steven's father is depressed with the simmering anger of having to play housewife and chief cook and bottle washer for his son. Until his unemployment, he viewed himself as a young, successful businessman on the move. Now, he is a failure.

The family situation is at highest risk for child abuse—a difficult child, resentful parent, severe financial stress, social isolation.

Mental health services and primary care services are not covered under his wife's policy. Even if there was money for the upfront fees at the regional community mental health center, the center is not sure how much longer its doors will remain open.

The neighborhood that Steve and his family lives in is viewed as very stable. Key referral resources such as public health nursing have been targeted elsewhere in the city. Being confronted with the inability to pay for health care, be it for immunizations or for illness, is demoralizing for the unemployed father, who always thought of himself as the self-sufficient provider for his family. Additionally, these families do not know what services are available, where to go, and even how to ask the questions to find out, and when they do find a service, it may likely not be available for these new medically needy.

Mr. Chairman and members of the committee, these are but a few of the thousands of examples of the tragic impact that unemployment and consequent loss of health insurance coverage has on people's lives. We urge you to act swiftly to provide some relief for these families.

We commend you on your efforts so far and stand ready to assist you in any way we can.

Thank you for the opportunity to express our views.

[The prepared statement of Ms. Badura follows:]

PREPARED STATEMENT OF MS. BADURA, AMERICAN HEALTH INSURANCE FOR THE
UNEMPLOYED

The American Nurses' Association is a national organization representing the nation's professional nurses. Registered nurses believe that the federal government has historically assumed a role that includes the determination of basic benefit levels to provide comprehensive health service, the establishment and maintenance of payment mechanisms, and the quality assurance procedures that facilitate access to quality care for all people. Emergent political and economic trends could diminish the federal government's role and responsibility in providing access to basic health services. Such a change could adversely affect the poor and medically indigent, the aged, the unemployed, women and children, the physically disabled, and the chronically mentally disabled who are at-risk populations and in the greatest need of access to comprehensive and cost-efficient health services including nursing services.

Unemployment is one of the most serious economic problems facing our nation today. Unemployment rates, the highest in forty years, have remained near or above 10 percent for some time. Currently, about 12 million people are without jobs but seeking employment, and many, many more are without jobs but have become discouraged from seeking work. The Labor Department has estimated that one out of every five families are affected by unemployment each year.

This high, sustained rate of unemployment has had serious consequences for the access to appropriate and necessary health care for those who have lost their jobs. It has been estimated that over 90 percent of those who become unemployed lose their health insurance coverage within a few months, nearly 11 million people, according to the Congressional Budget Office. The loss of health insurance coverage has severe consequences for access to health care services. In effect, the unemployed are in "limbo" in the health care delivery system. Loss of income coupled with loss of insurance, means that health care becomes prohibitively costly for many.

Additionally, complications to the unemployed status of the population abound. Most unemployed do not qualify for Medicaid or public health services because of eligibility income limits. When access to public health services require copayments, individuals with income above the minimum limits are forced to choose between health services, food, shelter, or other essential items. Often, public health services are inadequate, because of funding cuts in both block grants and categorical programs, to keep up with the demand for health care services created by the unemployed. The public hospitals, already increasingly burdened by Medicare and Medicaid cuts and the "dumping" of non-paying patients by other hospitals are being additionally taxed by this pressure to provide health care services for the unemployed.

It is apparent that double digit unemployment rates have created an enormous national health problem. It is equally clear that this Congress must act quickly to fill the large gap in our health care delivery system made so apparent by the sheer number of unemployed. We are not unmindful, however, of the costs associated with establish-

ing a health insurance program for the unemployed. We feel it is important, therefore, to ensure that a program designed to provide health insurance coverage for the unemployed is compatible with both the health care needs of the unemployed and with the need to provide services in a cost-efficient manner.

HEALTH CARE NEEDS OF THE UNEMPLOYED

There is considerable current documentation which supports the observation that the unemployed and families of the unemployed are subject to specific health problems such as increased risk in alcohol and other substance abuse, suicide, depression, infant mortality, family violence, exacerbation of chronic illnesses and nutritional and dental diseases.

In addition, there is a severe risk for the emergence of chronic disease and disability due to the postponement of treatment for so-called "minor" illnesses or symptoms such as colds, sore throats, ear infections, influenza, and infectious diseases. This latter problem is of particular significance for children, our nation's future, who will bear the brunt of preventable cardiovascular disease, hearing loss, brain damage, and physical deformity.

HEALTH SERVICES REQUIRED

Any federally financed health insurance program for the unemployed must consider the financing of services which are keyed to the greatest areas of risk. Therefore, the program must address the need for, first, routine out-patient services including pre and post natal maternity services as well as, well baby and well child services.

Second, provisions must be made for coverage of prescription drugs and supplies, i.e., dressings, crutches, insulin syringes, etc. We are receiving increasing reports of unemployed individuals who are

forced to forego the expense of prescribed treatment for chronic or acute illnesses, such as insulin for diabetes, high blood pressure medications, and antibiotics for infections.

Third, in light of the particular risk of unemployed with regard to alcohol and other substance abuse, suicide and depression and family violence, some provision must be made for crisis intervention services. Consideration should be given for coverage of essential in-patient services in these instances as well.

And finally, there should be coverage for acute in-patient hospital services which will provide for emergency hospitalization.

MATERNAL AND CHILD HEALTH SERVICES

The emergence of the tragic and shameful statistics on the increasing infant mortality rate in many large urban areas, particularly those areas hardest hit by unemployment, has clearly demonstrated the need to address services in this area.

Women with no employment income and no health insurance coverage have few options as to the health care available for the delivery of their children. Funding for state maternal and child health programs has been inadequate to allow these programs to keep up with the increased demand for services precipitated by higher rates of unemployment. As a result many pregnant women are not able to receive adequate prenatal care. Private hospitals require hundreds of dollars before they will accept the mother as a patient. Since this is impossible for most unemployed, the public hospitals have become their last resort. Many times, moreover, public hospitals may not have access to a mother's prenatal care records - if they exist - which means diagnostic tests have to be redone, a duplicative and unnecessary expense.

Moreover, we have heard instances where women recently affected by unemployment are unwilling to deliver in the public hospital. In such cases, the women have gone through labor in the parking lot of the hospital of their choice, to be able to deliver in that hospital when there is no longer the option of being transferred. Not only is this a sad situation, it is a serious health risk for both mother and child.

ACUTE, IN-PATIENT SERVICES

At a minimum, the unemployed must be protected against the overwhelming medical expenses associated with hospitalization for acute illness. It is clear that we cannot expect those who have lost their health insurance coverage, because of economic conditions beyond their control, to experience financial ruin due to a severe illness in the family. For many, the loss of health care insurance can be even more devastating than loss of earnings.

It has been well documented that the unemployed are in poorer health than those who are employed, primarily because of illnesses arising from the stress of being unemployed. Coupled with this, many unemployed often forego basic preventive and maintenance health services, because of financial constraints, which may then lead to more serious and costly illnesses. Coverage of acute in-patient services for medical or surgical problems must be considered as part of a basic benefit package for the unemployed. Without this stopgap measure, the unemployed will be forced on public assistance programs or to assume a large life-long debt.

OUT-PATIENT SERVICES

A crucial health care need for the unemployed is access to preventive and maintenance health care services, such as hospital out-

patient services or community based services. We feel strongly that the importance of this aspect of health care should not be overlooked in the development of a program to provide for the health needs of the unemployed.

We know, for example, that some unemployed people with no health insurance coverage will forego routine physical examinations, even though it is well-known that early detection and treatment of a health problem is much easier -- and less costly -- than treating a problem at a later stage.

The child who experiences ear pain or who has a sore throat may not see a health care professional, especially if the symptoms disappear after a few days; people with chronic conditions, such as diabetes or hypertension, forego routine monitoring treatment or delay reporting changes in treatment outcomes or state of well-being.

We know of one woman, who is unemployed and has hypertension, who regularly visits "Screening Fairs" in her community to get free blood pressure checks. This woman is to be admired for her ingenuity, yet we know many for whom this option is unrealistic. The tragedy of lack of services for conditions such as hypertension is that it is one of the most treatable diseases, with proper monitoring and medication, and one of the most deadly if left untreated.

Not unrelated to this is the fact that many of the unemployed who have been hospitalized are demanding early discharge, even when this goes against advice for good health. At the same time, we do not have the resources or the services to follow up these cases, nor do these people have access to home health care services, which in many cases would be appropriate to meet their health care needs.

Maintaining good health and preventing serious illness are the least costly ways to provide health care. For the unemployed, it is crucial. When these people are faced with a choice of meeting previously acquired financial obligations to paying for health care, it is almost always the health care which is forfeited.

CONCLUSION

The American Nurses' Association believes that the unemployed should be considered the nation's largest at-risk population, at-risk for health problems that require the attention of health care professionals. It is crucial that a program for providing essential health insurance coverage for the unemployed be designed. The magnitude of the problem of lack of adequate health insurance coverage for many millions of Americans and their families, points to the urgency of the need for action. We believe that such a program, at the very least, must provide for adequate care for mothers and children, for acute in-patient services, and for out-patient services.

We commend the Congress for its efforts to develop a program to provide for the health care needs of the unemployed. The American Nurses' Association stands ready to assist you in whatever way we can.

Senator QUAYLE. Thank you very much.

I suppose the first question that I have is are some of these people who are unemployed and do not have health insurance, are they being turned away from receiving any kind of health care from either physicians or the hospitals?

Dr. SAMMONS. Well, Mr. Chairman, I will speak for the physician population of the country. Regretably, I suspect that there are some who have been. I would not sit here and attempt to delude you into believing that all physicians are saints. I would admit that there probably have been instances in which that has occurred, which is deplorable. I would remind you again, however, that some 71 percent of the doctors in this country are, in fact, either providing services for free or at a much reduced rate. Therefore, I would also assume that the number of those unfortunate circumstances is small.

One can always find horror stories. You do not need to find a horror story to make the point that this country has the highest unemployment rate since World War II. You do not need a horror story to make the point that millions of people have lost coverage. You do not need a horror story to make the point that that loss of coverage does impact on health.

The facts are the facts, and it is a fact that that is where we are. That is why we believe that this Congress should act, and we believe it will. But yes, I suspect that there have been instances in

which doctors have done that, however deplorable that may be, but they are certainly in a minority. I cannot speak for the hospitals.

Senator QUAYLE. Mr. Epstein, is that the general assessment, are people being turned away who do not have health insurance coverage?

Mr. EPSTEIN. Well, I think you have got two kinds of problems, Mr. Chairman. What we heard in earlier examples are where persons decline to seek care even though they may need it, even on a nonemergency basis, and that is a problem that needs to be addressed by providing insurance for them. The other is the emergency situation, or where a procedure is needed. Now, in that case, all but a few of our States require that patients in need of care have access to the hospital and hospital facilities. The Hill-Burton requirements require access, and in fact, in 1980 there was given in service by hospitals \$7.5 billion of health care services.

So the rendering of care to the acutely ill, those who need to be hospitalized, is being done. It is the persons who may not be acutely ill, may not need surgical procedures, who may be postponing those procedures that we need to address ourselves to.

Senator QUAYLE. Dr. Cooper, do you have a comment?

Dr. COOPER. Yes, I would like to amplify on Dr. Sammons' and Mr. Epstein's responses. I asked 50 pediatricians what the impact of the unemployment was as they saw it, and I asked them about horror stories. In our community, there were not very many horror stories, and part of the problem is that we do not know the magnitude of the problem because of the pride which prevents people from coming in.

We do know, Senator Kennedy, that those women who come in, ready to deliver, without prenatal care, in a recent study in New York, had a tenfold increase in neonatal mortality over the rest of the city—tenfold. That is a serious problem.

And we do know that we are seeing people not come into our allergy clinics, so that we now see the kids in the emergency rooms with asthma. We see them failing to come in for follow-up on their treatment of middle-ear infection, and so we expect our problems with deafness to increase. We see kids with sickle cell disease and its variants who, when the families lose health insurance, stop coming in for the routine care that we know can prevent serious complications. So it is an awesome problem.

Senator QUAYLE. Do you have data to show how this has increased, say, in the last 3 or 4 years as the rate of unemployment has gone up? You have talked about the infant mortality rate, but will the other preventive health-type care normally provided under health insurance also be the evidence that we will find?

Dr. COOPER. There is going to be a lag for many of these things. In New York, where I work, the unemployment has not just shot up; we have had chronic under- and unemployment. So, if we had dumped on us what communities in Michigan and Alabama had, we might be seeing different numbers. But we have seen reductions in coming in for the kind of care that we know prevents long-term disabilities.

Senator QUAYLE. But what I am trying to do is to get the cause and effect, because I think preventive health is a major problem that we have had, but we have had that even at times of lower rate

of unemployment. And I want to see if we have a more serious problem in preventive health and these types of things, because of the unemployment. I mean, this has always been a problem, and what I am trying to document and to get the data for is to show this cause and effect, that if unemployment goes up, people do not have the access to health insurance, therefore, put off going in to the hospital, put off seeing their doctor, because they know they are not going to be able to pay for it, which translates into a decline in the quality of health of these individuals. That is what I am trying to get, and any data that anybody would have for the committee which could show this relationship, I think would be most helpful to demonstrate the relationship that there is between the recession, high unemployment with health care.

Dr. COOPER. The best data we have on child abuse is where, at the Saint Luke's site, there was a 50-percent increase in 1982 over 1981. That means from 120 cases to 180 in one hospital site. And we think that reflected further economic downturn.

Senator QUAYLE. My time is up.

Senator Metzenbaum.

Senator METZENBAUM. Dr. Sammons, we are pleased to have your testimony indicating your concern and support for a legislative approach, but I am not sure who speaks for the AMA, the executive director or the president, because 2 weeks ago, according to the Washington Post, there is a story indicating, "New Federal Programs Discouraged. AMA Says Doctors Caring for Jobless". The president of the American Medical Association yesterday told President Reagan that voluntary work by the Nation's doctors is doing a better job of providing health care to unemployed persons who are without medical coverage than any new Government program. The president of the AMA said that the problem of providing health care for the unemployed is best met by private physicians; it is a great problem, and we are meeting it.

Now, is he stating the AMA's position, or—

Dr. SAMMONS. Senator, I am delighted that you have raised this. Senator Dole was kind enough to raise it before the Senate Finance Committee to give us the opportunity to place in the record of the Senate Finance Committee, and Mr. Chairman, I would like the opportunity to place in the record of this committee, a letter written by Dr. Rial, who is the president of the American Medical Association, to the editor of the Washington Post, correcting that article. And also, I would like to inform the members of the committee that the Washington Post has, in fact, printed this letter since it was submitted to the editor on April 20.

Senator Metzenbaum, if you would read further on in that article down toward the end, you will find a statement attributed to Dr. John Coury, who is the vice chairman of the board of trustees of the American Medical Association from the State of Michigan, which correctly states the position of the AMA, and it is the same position that I have stated to this committee this morning.

With your permission, Mr. Chairman—

Senator QUAYLE. The letter will be inserted in the record, Dr. Sammons.

Dr. SAMMONS. Thank you very much.

[The letter referred to follows:]



AMERICAN MEDICAL ASSOCIATION

535 NORTH DEARBORN STREET • CHICAGO, ILLINOIS 60610 • PHONE (312) 751-6000 • TWX 910-221-0300

PRESIDENT

WILLIAM Y. RIAL, M.D.
111 Dartmouth Avenue
Swarthmore, Pennsylvania 19081

April 20, 1983

Editor
The Washington Post
1150 15th Street, N.W.
Washington, D.C. 20071

Dear Sir,

The April 20 article on the work that physicians are doing to provide free or low-cost care to the unemployed who have exhausted their health coverage gave the impression that I did not believe that federal involvement was necessary to help to cover the long-term costs of care, particularly hospital care and care for those unemployed due to the changing structure of our economy.

The quote attributed to Dr. Coury, Vice-chairman of the AMA Board of Trustees, reflects my views on this subject. Dr. Coury stated, "We recognize that the federal government has to have an increased part, no question about it. We also think it has to be a joint effort between industry and government and the physicians."

Sincerely yours,

William Y. Rial, M.D.
President

Senator METZENBAUM. I am glad to have that clarification. I was not aware of the letter to the editor, and I am glad to hear that the President and the executive director are both supportive.

Dr. SAMMONS. I am glad to hear that, too, Senator. There would be a problem if we were not.

Senator METZENBAUM. Let me ask you—you have indicated that the problem is pretty well being taken care of, because 71 percent of the physicians are treating patients without charge or at reduced rates. In my opening statement—I had heard this statement that the AMA and the physicians were providing coverage—in my opening statement, I pointed out that three of the largest cities in Ohio had set up referral programs, but that in more than half of the cases, the local medical society could not give us the name of a single physician who would see a patient without charge. And I have to say, Dr. Sammons, that I have done some further checking on my own, just at random, not done in any scientific manner, and I would guess that 71 percent is a misleading figure. Maybe some doctors would say, "Well, yes, I reduced my fees for some unemployed people," or something of that kind, but that it really does not state the facts as they are out there today for the unemployed workers of this country who are in need of medical care. I would say some doctors are providing assistance, but I would guess that it would be closer to reversing the figures, with maybe 29 percent at best providing the care, and 71 percent maybe having given some token help.

Dr. SAMMONS. Senator, my only comment is in two parts. First of all, I would like to ask you to allow your staff to share with us your inquiry into Ohio. I find that almost incomprehensible, knowing as much as I do about Ohio. I would really very much appreciate your sharing with us that information.

Senator METZENBAUM. My staff's information is available to you.

Dr. SAMMONS. The other comment I have to make is that just the week before last, the President invited in the 33 organized units around the country to the White House and did in fact have a ceremony commending them for the extent of the work that is being done. Now, you know, this entire country does not have a uniform population, and there are high centers of unemployment and high-density populations. In my old home town of Houston, the Harris County Medical Society has 2,000 members that are providing care on a referral basis, and the first day that program was in effect, I am told, they had over 3,000 phone calls and referrals. There are organized units all over this country, and yes, I think that doctors are responding and responding well.

The point that Mr. Epstein made earlier—Dick pointed out that there are multiple problems here. One is the problem of pride, one is the problem of access, one is the problem of liability. They cannot be lumped. Each one has to be addressed individually. I would appreciate the sharing of the information.

Senator METZENBAUM. We will do that.

Senator QUAYLE. Senator Kennedy.

Senator KENNEDY. Thank you.

Dr. Sammons, what percent of the unemployed are getting free or reduced care?

Dr. SAMMONS. I am sorry, Senator, I cannot answer that question. I do not know the answer to that question.

Senator KENNEDY. So we really do not know, of the millions of unemployed, their families and their children, you really cannot tell us how many of those individuals are actually getting treatment at this time?

Dr. SAMMONS. No. I am sorry, Senator, I cannot.

Senator KENNEDY. Can you tell us what the reduced payment is amounting to, say, in terms of the cost of delivering a baby? What is the reduction? The general figures are anywhere from \$2,000 to \$3,000 for delivery. How much is it being reduced?

Dr. SAMMONS. That figure you use is a little high, Senator.

Senator KENNEDY. Well, for hospital and physician.

Dr. SAMMONS. Oh, OK. The range would be all the way from zero to the full amount, and it is our experience that what is happening—in literal fact, what is happening—is that physicians are asking their patients if they are unemployed, if there is an unemployed head-of-household, or whatever the current phrase is—“maintaining a family,” I think is the current phrase—if that is the case, then whatever the extent of fiscal difficulty exists, the appropriate discounts are being made. But the range would be all the way from zero to full charges. The fact is that not all unemployed, as you very well know and the committee knows, not all unemployed are suffering financially; on the other hand, it is a fair assumption that the vast majority of unemployed are. And to the extent that they need help, we believe that they should have it, as we have testified, but that range goes from zero to full charge.

Senator KENNEDY. So you cannot tell us how much they are really reducing the fees.

Dr. SAMMONS. I can only tell you it is from zero to standard charge, and all in-between.

Senator KENNEDY. From no reduction to complete reduction?

Dr. SAMMONS. Yes.

Senator KENNEDY. Can you tell us how many doctors are requiring upfront money for treatment?

Dr. SAMMONS. I cannot answer that, but my own personal experience over the last 30 years tells me that that is a very small percentage. I have no way of answering that. We have never asked the profession that specific question, but 30 years in this business tells me that that is a very small number. And it should be zero.

Senator KENNEDY. Dr. Cooper, how frequently should a pregnant woman see a doctor for prenatal care? I guess the American Society of Obstetricians and Gynecologists says every 4 weeks for the first 28 weeks; every 2 to 3 weeks for the next 8 weeks; and weekly thereafter. Is that about your understanding?

Dr. COOPER. I am glad you reminded me; yes.

Senator KENNEDY. And how much does that prenatal care cost?

Dr. COOPER. Senator Kennedy, I would be guessing.

Senator KENNEDY. Well, is it about \$250 to \$300?

Dr. COOPER. Most obstetricians—

Senator KENNEDY. Not counting the delivery.

Dr. COOPER. Most obstetricians do not charge for just the prenatal care. They tend to charge for the entire obstetrical package.

Senator KENNEDY. Well, about \$1,450, as I understand, is normal delivery; \$2,500 for a caesarean, and professional fees come to about \$600 to \$800, for a cost of \$2,000 to \$3,000. Is that about right?

Dr. COOPER. Yes, in New York City.

Senator KENNEDY. Well, you commented earlier about these expectant mothers, women who are bearing children. I am just wondering what you can tell us about the reduced visits to hospitals for this kind of care. Has this been noticeable to your society and to your members?

Dr. COOPER. Senator, I do not have numbers in terms of rate of increase. I do know that in our voluntary hospitals in New York, out of survival, we do have cashiers at the front, and you do not get into the clinic unless you go through those cashiers. The only exceptions are the C and Y programs of which we have one, which give free preventive care, and the title V maternal and infant care programs. Everybody else has that cash register there, and that is the barrier.

Senator KENNEDY. Could I ask Ms. Badura what your own sense is about the numbers who are not receiving the kind of attention which is generally recommended for well-baby care?

Ms. BADURA. We do not have statistical data. We may have some coming soon on that. But what we are seeing is—because again, of the cash register being a barrier—the families are not seeking the care.

Senator KENNEDY. What do you mean by the cash register being a barrier? Can you explain?

Ms. BADURA. When someone enters a clinic, they are asked for payment of anywhere from \$3 to \$15 in the city of Chicago, based on a sliding scale system. That in itself, being asked for that payment, is a barrier for a family to seek care.

Dr. SAMMONS. Senator, could I answer your question, too?

Senator KENNEDY. Certainly.

Dr. SAMMONS. I think it is important that you remember what Dr. Cooper said. The average obstetrician in this country does not break down those kinds of fees, but once an obstetrician accepts a patient, the obstetrician expects that patient to come in and be seen, the frequency determined by the condition of the patient.

It is true that the college of ob-gyn has some recommended guidelines in terms of the frequency of visits, but it is equally true that those are simply guidelines and that obstetricians in this country change that frequency based on the condition of the patient. It is also true, in most metropolitan areas of the country that I am aware of, that care is obtainable in one of many forms for people who are without funds. The difficulty is the willingness of the person to seek those forms—the pride barrier, the lack of knowledge as to how to obtain it and so forth. But the frequency of visits in the prenatal state is determined almost exclusively on the basis of the patient's condition.

Senator KENNEDY. Well, that is the point. Should they change because of the financial consideration? And as I understand from Ms. Badura, they do, from her own experience. That is the point we are getting at.

Dr. SAMMONS. Well, Senator, we have already said this morning that we believe a program needs to be enacted to help alleviate that problem. So you and I are not on different sides of this coin at all. But the specific to your answer relative to frequency of visits is determined by the patient's condition.

Senator QUAYLE. Thank you, Senator Kennedy.

I have other questions myself, and others may want to submit questions to the panel for response. We will be working with all of you, I am sure, and I thank you for your testimony this morning.

Dr. SAMMONS. Thank you very much, Mr. Chairman, for the opportunity to be with you this morning.

Senator QUAYLE. The next panel includes, from the Indiana State Board of Health, Dr. Blankenbaker; from the Conference of City Health Officials, Dr. Shapiro.

The first witness, from the great State of Indiana, it is indeed an honor to have the State health commissioner with us today. Dr. Blankenbaker, welcome, and please go ahead and proceed.

STATEMENT OF DR. RONALD G. BLANKENBAKER, STATE HEALTH COMMISSIONER, INDIANA STATE BOARD OF HEALTH, INDIANAPOLIS, IND. AND DR. STUART SHAPIRO, COMMISSIONER OF HEALTH, CONFERENCE OF CITY HEALTH OFFICIALS, PHILADELPHIA, PA.

Dr. BLANKENBAKER. Mr. Chairman and members of the committee, I appreciate the opportunity to be here and speak with you about this very important problem.

Senator Quayle, greetings from home. If you can do anything about the weather I would appreciate it, we have too much rain.

Senator QUAYLE. It is coming this way.

Dr. BLANKENBAKER. I would like to present my comments very briefly. I have provided them in writing to you, and I would ask that the written comments be placed into the record.

One of the problems that I have found over the past week or two as I have really looked into this situation is that, as you have found this morning, there is not really very much known about how serious a problem we face today.

In Indiana in 1979, the second quarter, our unemployment rate was 6 percent. In the first quarter of 1982, it had risen to 12.7 percent, and it is hovering around 12 percent right now.

It is interesting to note that in the age group 16 to 24, unemployment is up to around 18 percent now, and that is a rather significant population. They are generally a healthy group, but they have many dependents, they are certainly getting pregnant and needing prenatal care and so forth. They do lack financial reserves and have not developed secondary skills. So this is a population group that I think we have to be very concerned about.

As we look at this unemployment problem and try to assess what the effect of this has been on health care, I am finding that really, no one knows. We assume that this has had a significant negative effect, but very little information is available on how serious the problem really is. In Indiana, we estimate that 550,000 citizens do not have health insurance. However, it is really not possible to de-

termine in an accurate way how many of those are unemployed and that that is the reason they do not have health insurance.

Assumptions about the impact of this recent displacement of workers may show in some statistics, and I will give them to you very briefly. In Indiana, the medicaid-eligible population, those enrolled in 1979 were 199,000; in 1982, that was 219,000. Those who used services on a monthly basis were 103,000 in 1979, and 119,000 in 1982. And the costs of medicaid have gone from \$309 million to \$482 million during that period.

Another interesting figure is that some doctors I have talked to have indicated that their practices are down as much as maybe 30 percent, which may indicate that patients are not going to see them because of unemployment.

I have asked some of the hospitals to give me an indication of their bad debt. A few selected hospitals in Indiana showed us an increase of 102 percent in their bad debt from 1979 to 1982—again, maybe these are indirect indications of the problem of unemployment and health care.

In Indiana, as you have heard from others, the professionals have really banded together and are working to provide free care for many of the people who need these services. Consequently, we have not seen it as a devastating effect. I get many complaints about a variety of public health problems; I have not received any complaints about this one.

We have a serious concern toward those who have recently been unemployed, and one of the reasons we are concerned about this is these people may have a pride that is preventing them from seeking care. They are used to paying for their bills, and now they are not able to, and our biggest fear is that they may not be going to the doctor and seeking this care, especially early on—the routine, preventive care—at a time when it is really needed. Consequently, they wait until it is critical; they go to the emergency room or the hospital for hospitalization, and that is certainly a more expensive approach to health care.

We are really hopeful in Indiana that whatever mechanism is developed here in Washington, that the aid to the displaced worker will address the issue of payment for primary, preventive ambulatory health care, as you somewhat alluded to earlier. Most importantly, I believe that a thorough study of the effects of displacement of health care needs to be made before any significant legislation is passed. We really believe it is uncertain just how serious it is.

As I alluded to in my written comments, as I see it, there are three approaches. One would be to do nothing; leave it as it is; let the system handle itself. You have heard that there are some programs—and certainly, we have seen it in Indiana—where the system is dealing with the problem itself. I would guess that this is probably the most cost-efficient way to resolve the problem. It certainly would prevent the needs of administrative and government costs, and it probably does discourage unnecessary utilization. However, the pride of the individuals, as I said earlier, may delay care until the costs are less expensive. Another disadvantage is that those who can pay subsidize the care of those who cannot.

The second approach, entitlement program, we would disfavor, primarily because we believe it would result in a program that would go on, unending and would be very expensive. However, one of the advantages is that every taxpayer would then pay into the cost of the program. Certainly, another disadvantage is that this could, if it is an entitlement program such as medicare and medicaid, discourage primary ambulatory preventive health care, and it is likely to be the most expensive.

Last, the third approach would be a block grant approach. Seeing that Indiana does not really understand at this point how serious a problem we have, where the pressure areas are, and what the needs of our people in Indiana really are, we would prefer that a program to support the problems of the unemployed, the displaced worker, come to Indiana in the form of a block with the flexibility so that we could work with the various agencies, individuals, professions, and so forth, to develop a more cost-efficient program for Indiana.

Mr. Chairman, I thank you very much for the opportunity to speak today.

Senator QUAYLE. Thank you very much Dr. Blankenbaker.

[The prepared statement of Dr. Blankenbaker follows:]

PREPARED STATEMENT OF DR. BLANKENBAKER, ON HEALTH CARE FOR DISPLACED
WORKERS

I. The Problem of the Displaced Worker

A. Unemployment in Indiana:

The State of Indiana is highly industrialized and, therefore, the recent recession has created a significant loss of jobs. The State's unemployment rate was 6 percent in the second quarter of 1979 (159,180 jobless), had risen to 12.7 percent in the first quarter of 1982 (329,653), and is still hovering around 12 percent. (For a more detailed breakdown, see Table I.)

During this same period a breakdown of the various sectors of the economy showed that: 197,000 jobs were lost in the manufacturing sector; 179,000 in durable goods; and 79,200 in nonmanufacturing sectors.

The distribution of the unemployed in Indiana by age is shown in Table II. A large segment of Indiana's displaced workers come from the age group 16-24 with an unemployment rate in 1982 of 18 percent. Although this population is generally healthier than other age groups, the Indiana Department of Commerce notes that a large number of these young unemployed have dependants in need of health care. Additionally, this group has not worked long enough to develop financial reserves or secondary skills to compensate for their current quandry.

B. Effect of Unemployment on Health Care

Although we all assume that the recently displaced worker has difficulty getting adequate health care, very little information is available to determine how serious a problem this really is. In Indiana we estimate that 550,000 citizens do not have health insurance; however, it is not possible to accurately determine what percentage of these is due to work displacement. Most probably it is a significant segment.

We can make some assumptions about the impact of the recent increase in displaced workers through the following statistics:

	<u>1979</u>	<u>1982</u>
Indiana Medicaid Eligible		
Enrolled	199,844	219,958
Used Services on a Monthly Basis	103,729	119,870
Medicaid Costs	\$309,568,788	\$482,920,116

Additionally, visits to physicians offices have decreased significantly in many areas. Some doctors report that their patient office visits are down by as much as 30 percent.

In Indiana much has been done to offset the recently unemployed's loss of ability to pay for health care. Business/medicine coalitions, hospitals, medical societies, various health agencies, and individual professionals have worked together to develop free services for these displaced workers. This is generally reminiscent of the pre-Medicaid/Medicare days when patients were cared for in spite of their ability to pay. Consequently, we have not seen the devastating effect of displacement on health care that may be present in other states.

However, we have a serious concern toward the recently unemployed individual whose pride prevents him or his family from seeking necessary health care. These former workers are solid citizens who were used to paying their bills on time and many have never needed to ask for financial help. Our biggest fear is that these people will hold off seeking routine or preventive health care until something more urgent or serious develops. This would result in trips to the emergency room or stays in the hospital which are certainly the more expensive aspects of health care and could possibly have been prevented by prudent primary, ambulatory care. This

not only would create unnecessary costs but would encourage a lesser quality of life.

For these reasons we are hopeful that whatever mechanism is developed by the federal government to aid the displaced worker will address the issue of payment for primary/preventive ambulatory health care.

II. Potential Solutions for Health Care of the Displaced Worker

A. Rely on Current Health Care Delivery System

As stated above, the current system is capable of absorbing the health care costs of the displaced worker. Indiana has taken this approach to date.

1. Advantages

- a. Probably the most cost-efficient approach
- b. Prevents the need of government administrative costs
- c. Less worry about fraud, etc.
- d. Discourages unnecessary utilization

2. Disadvantages

- a. Pride of individual may delay care until more serious and expensive
- b. Those who can pay subsidize the care of those who cannot
- c. There are no assurances that system will accept this responsibility

B. Create an Entitlement Program

Much of the discussion to date has centered around the development of another entitlement program similar to Medicaid. We do not favor this approach at this time because the disadvantages far outweigh the positive benefits.

1. Advantages

- a. Make health care available to the displaced/uninsured worker

- b. Could encourage the timely seeking of health care
- c. Places the federal government in control of the program
- d. Every taxpayer share in the cost of the program

2. Disadvantages

- a. May encourage overutilization of expensive services, abuse and fraud
- b. May discourage use of primary, ambulatory, and preventive health care
- c. Likely to be the most expensive approach
- d. Likely to continue after the recession is over and become an expensive long-range health care entitlement program similar to Medicare/Medicaid
- e. Likely to stereotype the health care needs of this population; i.e., will not adequately recognize the complexity of the problem and the unique problems from region to region and state to state
- f. Will not give the state adequate involvement in the administration/control of the program

C. Block Grants to States

If the federal government develops a funding program for the displaced worker, we would favor the Block Grant approach because we believe the advantages for Indiana would far outweigh the disadvantages. We have had a very good experience with the Block Grant concept in the past several years and have found it a very cost-efficient approach to Indiana's needs.

1. Advantages

- a. Allows each state to analyze its specific needs and develop its program accordingly

- b. Places the administration of the program closer to those receiving the benefits--this should make the program more sensitive to those eligible and their needs
- c. Would allow the state to work cooperatively with providers, consumers, agencies, etc., to more cost-efficiently use these funds

2. Disadvantages

- a. The federal government has less control and, therefore, less assurance that its wishes will be carried out.
- b. Decisions may be unduly influenced by local/state politics

III. Recommendations for a Health Insurance Package for the Displaced Worker

We have discussed the problem of the displaced worker with many individuals and agencies, including Blue Cross/Blue Shield, the Indiana Hospital Association, the Department of Public Welfare, and the Department of Commerce. Consequently, we would like to make the recommendations outlined in Attachment I.

I thank you for the opportunity to present our feelings to the Committee about this most important problem.

There should be a concurrent review program, such as the 50th percentile, according to PAS.

Funding

Funding would be provided on a matching basis using the Medicaid matching formula by the Federal government.

The remainder might come from a combination of:

1. Per capita union contributions
2. Corporate contributions
3. Community Fund Drives - special promotions
4. A special tax through county welfare departments
5. Temporary increase in the unemployment tax rate

Administration

Health insurance pool which has already been established for the "uninsurables"

HEALTH INSURANCE FOR THE UNEMPLOYEDInsurance industry develop and price a packageGeneral benefit provisions:

- Cover hospital and physicians' regular charges
- Coverage would be non-elective inpatient admissions and medically pre-certified
- Benefits provided for up to 30 days/person/year
- Outpatient service with sizeable copayment by recipient
- Unemployed individual and dependents would be covered
- 20% co-payment to the provider

Eligibility requirements/restrictions:

To be eligible, the individual would be required to provide proof of prior health care coverage that was terminated due to layoff and coverage unavailable through a related policy holder(s). Former employers would be required to provide proof of prior coverage and a statement that unemployment was due to layoff, not to voluntary termination or having been dismissed.

The program would be available for up to one year after determination of eligibility, or, until eligible by reason of employment, whichever occurs first.

Participants in or individuals eligible for the Medicaid program would not be eligible for this insurance program.

Other payment conditions:

Where possible, hospitals would apply charges not covered, to Hill-Burton charity obligations.

TABLE I

INDIANA

TOTAL UNEMPLOYMENT

<u>Year: Quarter</u>	<u>Labor Force</u>	<u>Unemployed</u>	<u>Unemployment Rate (percent)</u>
79:2	2,658,127	159,180	6.0
3	2,666,621	171,722	6.4
4	2,649,563	180,483	6.8
80:1	2,606,928	226,459	8.7
2	2,663,638	264,882	9.9
3	2,627,572	270,419	10.3
4	2,629,863	246,240	9.4
81:1	2,609,873	286,056	11.0
2	2,651,378	259,803	9.8
3	2,620,399	235,340	9.0
4	2,626,321	274,801	10.5
82:1	2,596,979	329,653	12.7
2	2,611,033	298,692	11.4
3	2,582,116	286,573	11.1
4	2,585,871	325,082	12.6

TABLE II

INDIANA

AGE DISTRIBUTION OF UNEMPLOYED
(numbers in thousands)

	<u>Labor Force</u>	<u>Unemployed</u>	<u>Unemployment Rate</u>
<u>16-24</u>			
1979	692	93	13.4
1980	649	114.2	17.6
1981	627	113	18.0
<u>25-64</u>			
1979	1851	71	3.8
<u>25-54</u>			
1980	1599.8	127.4	8.0
1981	1626	136	8.4
<u>55+</u>			
1980	381.3	11.2	2.9
1981	364	15	4.1
<u>65+</u>			
1979	68	3	4.4

Dr. Shapiro.

Dr. SHAPIRO. Mr. Chairman, today in my few minutes, I would like to talk about the problems that I, as a health commissioner, face in attempting to assure that all Philadelphia citizens, including the unemployed, receive needed health services.

Philadelphia is a very useful example, because it mirrors the condition of many of the older industrial centers in this country. My city has a disproportionate number of poor and elderly residents and a troubled economy. Simultaneously, the tax base is declining. In fact, one in five Philadelphians pay for their health care using medical assistance, and over 60 percent of hospital in-patient reimbursement comes from medicare and medicaid.

Frankly, the sharply diminished Federal support over the last 3 years has had a crippling and chilling effect on our capacity to develop health services in Philadelphia, and I do have data. Not only in Philadelphia, but throughout this country, the effects have been chilling.

For many years, our health care system in this country has been held together with Band-Aids and suture material. Hospitals and other health care providers have been robbing Peter to pay Paul. Providers have been taking money from insurance companies to cover some of the bad debts from nonpaying patients. Hospitals have been inflating medicare charges and inflating Blue Cross

charges in order to support the underpayments for medicaid and in order to cover the uninsured. Hospitals have struggled to balance their books. Fortunately, by and large, they have succeeded. However, Federal policy today, combined with the increasing number of uninsured and impoverished patients, is changing the hospitals' capacity and other providers' ability to find enough money in Peter's pocket to pay Paul's bill.

Although today's hearing is on health insurance for the unemployed, we are really talking about assuring adequate dollars in a health care system that will allow us to hold the system together while necessary reform is taking place—reform that must take place. Costs are too high, and they are going up too fast.

I have surveyed over 1,000 agencies in Philadelphia, and data is now coming in. It shows that almost every agency is reeling from the cutbacks in Federal programs. The theory is that the cuts in Federal spending, in block grants, and in medicare and medicaid would be replaced by private philanthropy, and increased tax revenue generated by a reinvigorated economy, has proven false in Philadelphia. For Philadelphia and other industrial cities, that theory has been only wishful thinking.

Another study of the hospital industry in Philadelphia which we are just completing shows that free care and bad debts in the Philadelphia area are going to cost our institutions over \$100 million this year. Several institutions which are located in the poorest neighborhoods are much too close to collapse for comfort.

At some of the city's own health centers—and the city operates nine—we have been seeing a 25-percent increase in patients over the last 2 years. Many of the individuals coming to our health centers have never before used a public clinic. They are telling us they are doing so today only because they are unemployed, and they have lost their health insurance.

Because of the financial crises that hospitals are facing, some hospitals have begun in Philadelphia to demarket services. They are trying to treat as few uninsured patients as they can get away with—not because they have changed philosophically, but because they are financially imperiled. Some hospitals are demanding hundreds of dollars in deposits before they will let the uninsured pregnant woman through the turnstiles into their clinic for prenatal care.

Yes, in America today, that is happening. Hundreds of young teen-age girls are not getting adequate prenatal care. You or I or our families would have the sophistication to attempt to negotiate a lower rate maybe, but that 13- or 15-year-old girl is too frightened. She does not know how to negotiate a system. She is discouraged. But what happens? She appears in the hospital, in the emergency room, when her cervix is dilated, she is having cramps every 3 minutes, and there are no medical records. The result: higher infant mortality, more mental retardation, more physical health problems, and ultimately, higher costs to society. In fact, our infant mortality rate in Philadelphia, which had been going down, is now on the uprise. And, tragically, for nonwhites during the first half of 1982, there were almost 26 death per thousand births. That is against a national average of 11.3. That is almost 26 births per 1,000 live births. We have many other examples of deferred treat-

ment, which I do not have time to go into, but I will be glad to do during the questioning, some examples are also included in my full statement.

What I have been trying to tell you in this few moments is that our health care system cannot absorb nor afford more unemployed and uninsured citizens any longer. The plug has been pulled. The system is on "tilt." Not having reimbursement for the unemployed is the straw that is breaking the system's back. We do not want to bankrupt our institutions, because if we do, the institutions will not exist to care for any of us. The problem goes beyond the care for just the poor.

I am hopeful that this committee will report legislation expanding Federal reimbursement for health services to the unemployed. I would suggest that this committee consider a mechanism, at least on a demonstration basis, experimental basis, that would allow local governments, if they wished, to receive funds directly to arrange for or deliver health services to the unemployed. One of the deficiencies of the current block grant system, I believe, is that it does not allow the flexibility for the local governments to receive the money directly.

In conclusion, Mr. Chairman, and distinguished members of this committee, I hope I have been clear. We need health insurance for the unemployed, but the implications go far beyond the unemployed and the poor—the hospital system, the nursing home system, the ambulatory care system utilized by all Americans is in grave danger because of current health policy.

Over the last 3 years, our institutions and the people they serve have become anemic as their financial lifeblood has been slowly drained from their system. Some of them are now severely crippled, barely able to breathe, and not in a position to withstand another shock. Health insurance for the unemployed is an absolutely necessary transfusion, for without it, our health care system, already frail, may rapidly bleed to death, and the achievements of the past decade will be lost.

Thank you, Mr. Chairman.

[The prepared statement of Dr. Shapiro follows:]

PREPARED STATEMENT OF STUART SHAPIRO, M.D., COMMISSIONER OF HEALTH, CITY OF
PHILADELPHIA

MR. CHAIRMAN AND DISTINGUISHED MEMBERS OF THIS SUBCOMMITTEE, I AM DR. STUART H. SHAPIRO. CURRENTLY I AM THE HEALTH COMMISSIONER OF THE CITY OF PHILADELPHIA AND AM PLEASED TO BE HERE TODAY. I AM ALSO AUTHORIZED TO SPEAK ON BEHALF OF THE UNITED STATES CONFERENCE OF CITY HEALTH OFFICERS.

IN THE HEARING TODAY AND IN OTHER HEARINGS OF THIS SUBCOMMITTEE, YOU WILL HEAR STATISTICS, YOU WILL HEAR LOTS OF NUMBERS, AND YOU WILL HEAR PLEAS FOR MORE DOLLARS. I COULD DO THAT, BUT INSTEAD I WOULD LIKE TO MOVE AWAY FROM THE COLD NUMBERS AND TALK INSTEAD ABOUT PEOPLE, HEALTH CARE INSTITUTIONS, AND THE PROBLEMS THAT I, AS A HEALTH COMMISSIONER, FACE IN ATTEMPTING TO ASSURE THAT OUR CITIZENS RECEIVE NEEDED HEALTH SERVICES. I WILL DO THIS BY BRINGING YOU INTO PHILADELPHIA AND INTRODUCING YOU TO SOME OF OUR PROBLEMS.

PHILADELPHIA IS A USEFUL EXAMPLE BECAUSE IT MIRRORS THE CONDITIONS IN MANY OF THE OLDER INDUSTRIAL CENTERS IN THIS COUNTRY. THE CITY HAS A DISPROPORTIONATE NUMBER OF POOR AND ELDERLY RESIDENTS AND A TROUBLED ECONOMY. THE TAX BASE IS DECLINING LEAVING LESS MONEY AVAILABLE TO PROVIDE MANY BASIC SERVICES. AT THE SAME TIME, THE DEMAND FOR HUMAN SERVICES HAS INCREASED, AND IS INCREASING FURTHER, BECAUSE THE CITY'S POPULATION IS RAPIDLY BECOMING POORER, OLDER, AND MORE UNEMPLOYED.

INDEED ONE IF FIVE PHILADELPHIANS PAYS FOR THEIR HEALTH CARE USING MEDICAL ASSISTANCE AND OVER 60% OF HOSPITAL INPATIENT REIMBURSEMENT COMES FROM MEDICARE AND MEDICAID.

I CITE THESE STATISTICS BECAUSE THIS HEARING, ALTHOUGH FOCUSING ON HEALTH INSURANCE FOR THE UNEMPLOYED, IS REALLY ABOUT MUCH MORE. THE HEARING TODAY IS REALLY ABOUT THE COLOSSAL FAILURE OVER THE LAST THREE YEARS OF FEDERAL POLICY IN HEALTH SERVICES. THE HEARING TODAY IS REALLY ABOUT THE CRIPPLING AND CHILLING EFFECTS THAT SHARPLY DIMINISHED FEDERAL SUPPORT HAS WROUGHT ON OUR HEALTH CARE SYSTEM.

NOT ONLY IN PHILADELPHIA, BUT THROUGHOUT THE COUNTRY, THE HEALTH CARE SYSTEM IS IN CRISIS. FOR MANY YEARS THE SYSTEM HAS BEEN HELD TOGETHER WITH BANDAIDS AND SCOTCH TAPE. HOSPITALS AND OTHER HEALTH CARE PROVIDERS HAVE BEEN ROBBING PETER TO PAY PAUL. PROVIDERS HAVE BEEN TAKING MONEY FROM INSURANCE COMPANIES TO COVER SOME OF THE BAD DEBTS FROM NON-PAYING PATIENTS. HOSPITALS HAVE BEEN INFLATING MEDICARE AND BLUE CROSS CHARGES IN ORDER TO SUPPORT THE UNDERPAYMENTS FROM MEDICAID, AND THE UNINSURED. HOSPITALS HAVE STRUGGLED TO BALANCE THEIR BOOKS, AND BY AND LARGE THEY HAVE SUCCEEDED. FEDERAL POLICY TODAY, COMBINED WITH THE INCREASING NUMBER OF UNINSURED AND IMPOVERISHED PATIENTS, IS CHANGING THE HOSPITALS AND OTHER PROVIDERS ABILITY TO FIND ENOUGH MONEY IN PETER'S POCKET TO PAY PAUL'S BILLS.

HOSPITALS TODAY, AND OTHER HEALTH CARE PROVIDERS, ARE DISPENSING MORE FREE CARE AND ABSORBING MORE BAD DEBT THAN EVER BEFORE. I DO NOT BELIEVE THAT IF WE CONTINUE ON THE COURSE OF THE "NEW FEDERALISM" OF THE LAST THREE YEARS THAT THE HEALTH CARE SYSTEM, AS WE CHERISH IT TODAY, WILL SURVIVE. OUR HEALTH CARE SYSTEM IN PHILADELPHIA, AND IN MANY PLACES IN THIS GREAT COUNTRY, IS LIKE A FINE SILK NOT A STURDY COTTON, AND IF WE DESTROY THE FABRIC OF THE AGENCIES PROVIDING CARE OR PERMANENTLY WEAKEN THEM BY FORCING THEM TO USE ENDOWMENTS FOR ROUTINE OPERATING EXPENSES, BY REDUCING STAFF INAPPROPRIATELY, OR CUTTING SERVICES TO PATIENTS, THEN EVEN IF BY SOME MIRACLE THE PROGRAM FOR ECONOMIC RECOVERY DOES WORK, WE WILL HAVE VIRTUALLY NO HEALTH SYSTEM REMAINING.

THAT IS WHY THE HEARING TODAY IS REALLY ON A MUCH BROADER SUBJECT THAN HEALTH SERVICES AND HEALTH INSURANCE TO THE UNEMPLOYED. Yes, THAT IS VERY IMPORTANT. HOWEVER, WE ARE REALLY TALKING ABOUT ASSURING ADEQUATE DOLLARS IN THE HEALTH CARE SYSTEM THAT WILL ALLOW US TO HOLD THE SYSTEM TOGETHER WHILE NECESSARY REFORM IS TAKING PLACE. REFORM THAT MUST TAKE PLACE.

IN ORDER TO ASSESS THE CONSEQUENCES OF THE "NEW FEDERALISM" OF THE LAST THREE YEARS, I UNDERTOOK A YEAR AGO A STUDY OF OVER 1,000 AGENCIES IN PHILADELPHIA.

THE RESULTS ARE COMING IN NOW, AND I CAN ASSURE YOU THAT THE AGENCIES SURVEYED AND THE CITIZENS THEY SERVE ARE BOTH IN CRISIS. ALMOST EVERY AGENCY IS SUFFERING, AND TRAGICALLY THOSE AGENCIES WHICH RECEIVE THE LARGEST SHARE OF THEIR PROGRAM DOLLARS FROM GOVERNMENT FUNDS ARE FACING THE GREATEST RISK OF SURVIVAL. DAILY WE ARE SEEING HOW BAD THINGS ARE AND HOW BAD THEY ARE BECOMING. THE THEORY THAT THE CUTS IN FEDERAL SPENDING, IN BLOCK GRANTS, AND IN MEDICARE AND MEDICAID, WILL BE REPLACED BY PRIVATE PHILANTHROPY AND INCREASED TAX REVENUE GENERATED BY A REINVIGORATED ECONOMY HAS BEEN PROVEN FALSE. FOR PHILADELPHIA AND OLDER INDUSTRIAL CITIES THAT THEORY HAS BEEN ONLY WISHFUL THINKING.

WE ARE ALSO COMPLETING A SECOND STUDY OF THE HOSPITAL INDUSTRY IN PHILADELPHIA, AND I CAN ALSO ASSURE YOU THAT BECAUSE OF FEDERAL POLICY, FREE CARE AND BAD DEBTS IN PHILADELPHIA ARE GOING TO COST OUR INSTITUTIONS \$100 MILLION THIS YEAR. HOSPITALS WHICH IN THE PAST HAVE BEEN MOST STABLE, AND HAD SUCCESSFULLY WEATHERED PREVIOUS CRISIS WITHOUT PROBLEMS, ARE NOW IN TROUBLE. THE CRIPPLING EFFECTS OF THE CUTBACKS IN MEDICARE, THE REMOVAL OF CATEGORICAL PROGRAMS AND THE NUMBER OF UNEMPLOYED CONSUMERS HAVE FORCED MANY HOSPITALS INTO TRUE CRISIS. A FEW HOSPITALS IN PHILADELPHIA ARE CURRENTLY NOT GENERATING ENOUGH INCOME TO MEET THEIR DEBTS. SEVERAL INSTITUTIONS WHICH ARE LOCATED IN THE POOREST NEIGHBORHOODS ARE CLOSE TO COLLAPSE.

THE HOSPITALS, OUR HEALTH CARE INSTITUTIONS, AND THE CITIZENS WE ARE ALL SERVING ARE FEELING THE PAIN OF ABANDONMENT FROM FEDERAL POLICY.

AT SOME OF THE CITY'S HEALTH CENTERS THERE HAS BEEN A 25% INCREASE IN PATIENTS OVER THE LAST TWO YEARS. MANY OF THE INDIVIDUALS COMING TO OUR HEALTH CENTERS HAVE NEVER BEFORE USED A PUBLIC CLINIC, TELLING US THAT THEY ARE DOING SO NOW ONLY BECAUSE THEY ARE UNEMPLOYED AND HAVE LOST THEIR HEALTH INSURANCE. THE HEALTH DEPARTMENT HAS INCREASED ITS SERVICES BY INCREASING PRODUCTIVITY. THAT ELASTICITY IS NOW GONE AND WE, LIKE MANY HOSPITALS, ARE SCHEDULING APPOINTMENTS FURTHER AND FURTHER AWAY FROM WHEN THEY ARE NEEDED.

BECAUSE OF THE FINANCIAL CRISIS THAT HOSPITALS ARE FACING, SOME HAVE BEGUN TO DEMARKET THEIR SERVICES. THEY ARE TRYING TO TREAT AS FEW UNINSURED PATIENTS AS POSSIBLE, NOT BECAUSE THEY HAVE CHANGED PHILOSOPHICALLY, BUT BECAUSE THEY ARE FINANCIALLY IMPERILED. SOME HOSPITALS ARE DEMANDING HUNDREDS OF DOLLARS IN DEPOSITS BEFORE THEY WILL ALLOW THE UNINSURED PREGNANT WOMAN TO GET THROUGH THE TURNSTILES OF THEIR CLINIC FOR PRENATAL CARE.

HUNDREDS OF YOUNG TEENAGE GIRLS ARE THUS NOT GETTING ADEQUATE PRE-NATAL CARE TODAY. YOU OR I OR OUR FAMILIES HAVE THE SOPHISTICATION TO ATTEMPT TO NEGOTIATE OURSELVES THROUGH THAT TURNSTILE BUT THE 13 OR 15 YEAR OLD GIRL IS TOO FRIGHTENED, FIRST OF HER PREGNANCY -- OFTEN UNPLANNED AND UNWANTED -- AND THEN OF THE BILLING CLERKS AND BUREAUCRATS IN THE HOSPITAL. SHE DOES NOT KNOW HOW TO NEGOTIATE THE SYSTEM SO THE RESULT IS, SHE GETS NO CARE. SHE APPEARS AT THE HOSPITAL EMERGENCY ROOM ONLY WHEN HER CERVIX IS DILATED AND SHE IS HAVING CRAMPS EVERY THREE MINUTES AND HAS NO CHOICES BUT TO APPEAR IN THE EMERGENCY ROOM. OBVIOUSLY SHE HAS NO MEDICAL RECORDS. THE RESULT--HIGHER INFANT MORTALITY, MORE MENTAL RETARDATION, MORE PHYSICAL HEALTH PROBLEMS, AND ULTIMATELY HIGHER COSTS TO SOCIETY. IN FACT, THE INFANT MORTALITY RATE IN PHILADELPHIA, WHICH HAD BEEN GOING DOWN, DOWN, DOWN FOR THE LAST SEVERAL YEARS, HAS NOW TAKEN AN UPWARD SWING. AND, TRAGICALLY, INFANT MORTALITY FOR NON-WHITES DURING THE FIRST HALF OF 1982 WAS 25.6 DEATHS PER THOUSAND BIRTHS. THAT RATIO IS MORE THAN DOUBLE THE NATIONAL AVERAGE OF 11.3. WELL OVER 300 BABIES ARE DYING IN PHILADELPHIA UN-NECESSARILY. THAT MUST BE STOPPED.

WE'RE ALSO SEEING DELAYS IN MEDICAL CARE ELSEWHERE AND WE'RE SEEING THE ADDED COSTS OF DELAYED TREATMENT. RECENTLY A YOUNG MAN IN HIS EARLY 30'S CAME INTO THE EMERGENCY ROOM OF A LOCAL HOSPITAL WITH A BAD COLD AND WAS GIVEN A PRESCRIPTION FOR AN ANTIBIOTIC. SEVERAL DAYS

LATER, HE RETURNED WITH PNEUMONIA AND HAD TO BE ADMITTED TO THE HOSPITAL. WHEN ASKED WHETHER HE HAD TAKEN THE MEDICINE THE PATIENT TOLD THE NURSE HE HAD NEVER HAD THE PRESCRIPTION FILLED BECAUSE WITH A FAMILY, NO JOB, AND NO MEDICAL INSURANCE, HE COULDN'T AFFORD A SIMPLE PRESCRIPTION. UNFORTUNATELY TODAY HE ATE UP MUCH MORE OF OUR HEALTH CARE RESOURCES AND WAS PUT INTO THE HOSPITAL.

ANOTHER TRAGIC EXAMPLE THAT I'VE LEARNED ABOUT IS THAT OF A SIX YEAR OLD BOY WHOSE FATHER IS JOBLESS. THE CHILD HAS ASTHMA WITH NOT INFREQUENT ATTACKS. THE ATTACKS ARE OFTEN TRIGGERED BY JUST A SLIGHT COLD. IN THE PAST, WHEN THE CHILD HAD AN ACUTE ASTHMATIC ATTACK, THE FATHER OR MOTHER WOULD TAKE THE CHILD TO THE EMERGENCY ROOM OR TO SEE THEIR DOCTOR. MEDICINE WOULD BE GIVEN, AND THE CHILD WOULD BE BETTER QUICKLY. NOW THE FAMILY CAN'T AFFORD TO SEE THE DOCTOR OR GO TO THE EMERGENCY ROOM. BECAUSE A SLIGHT COLD CAN TRIGGER THE ASTHMATIC ATTACK AND THE FATHER IS FEARFUL THAT THE CHILD WILL GET A COLD IN SCHOOL, HE'S KEPT THE CHILD OUT OF SCHOOL AND AT HOME DURING THE WINTER SEASON. THUS WE HAVE A SIX YEAR OLD NOT GETTING HIS EDUCATION BECAUSE THE FATHER IS AFRAID OF THE POTENTIAL COST OF MEDICAL CARE.

WHAT I'VE BEEN TELLING YOU IS THAT OUR HEALTH CARE SYSTEM CANNOT ABSORB OUR UNEMPLOYED AND UNINSURED CITIZENS. THE PLUG HAS BEEN PULLED. THE SYSTEM IS ON "TILT". NOT HAVING REIMBURSEMENT FOR THE UNEMPLOYED IS THE STRAW THAT HAS BROKEN THE SYSTEM'S BACK. WHEN UNEMPLOYMENT GOES UP BY JUST A FEW PERCENT, BAD DEBTS TO HOSPITALS, DOCTORS AND OTHER PROVIDERS ALSO GO UP A FEW PERCENT. OUR HEALTH CARE SYSTEM IS FRAIL AND BY NOT COVERING THE UNEMPLOYED, OUR FRAIL HEALTH CARE SYSTEM MAY FAIL. WE DO NOT WANT TO BANKRUPT OUR INSTITUTIONS BECAUSE IF WE DO THE INSTITUTIONS WILL NOT EXIST TO CARE FOR ANY OF US, NOT JUST THE POOR.

THIS COMMITTEE SHOULD REPORT LEGISLATION EXPANDING FEDERAL REIMBURSEMENT FOR HEALTH SERVICES TO THE UNEMPLOYED. I AM HOPEFUL THAT YOU WILL ALLOW THE FUNDS TO BE USED IN A COST-EFFECTIVE MANNER. WE DO NOT SIMPLY NEED MORE MONEY AND NO CHANGE IN REIMBURSEMENT POLICIES. I WOULD SUGGEST THAT THIS COMMITTEE CONSIDER MECHANISMS THAT WOULD ALLOW LOCAL GOVERNMENTS, IF THEY WISH, TO RECEIVE FUNDS DIRECTLY TO ARRANGE FOR OR DELIVER HEALTH SERVICES TO THE UNEMPLOYED. ONE OF THE DEFICIENCIES OF THE BLOCK GRANT SYSTEM, I BELIEVE, IS THAT IT DOES NOT ALLOW THE FLEXIBILITY, CURRENTLY, FOR LOCAL GOVERNMENTS TO RECEIVE A FIXED AMOUNT OF MONEY DIRECTLY FROM THE FEDERAL GOVERNMENT. AN EXTRA LAYER, BUREAUCRATICALLY AND POLITICALLY, IS INTRODUCED AT THE STATE LEVEL

WHICH OFTEN MEANS THAT ADMINISTRATIVE COSTS ARE HIGHER AND DOLLARS THAT COULD BE USED FOR SERVICES ARE LESS. I WOULD SUGGEST THAT THIS COMMITTEE LEAVE OPEN THE OPTION, AT LEAST ON AN EXPERIMENTAL BASIS, TO ALLOW INNOVATIVE GOVERNMENTS TO ATTEMPT INNOVATIVE SOLUTIONS TO ASSURING THE DELIVERY OF HEALTH SERVICES TO THE UNEMPLOYED.

I HOPE I'VE BEEN CLEAR. WE NEED HEALTH INSURANCE FOR THE UNEMPLOYED BUT THE IMPLICATIONS GO FAR BEYOND CARE FOR THE UNEMPLOYED AND THE POOR. THE HOSPITAL SYSTEM, THE NURSING HOME SYSTEM, THE AMBULATORY CARE SYSTEM UTILIZED BY ALL AMERICANS IS IN GRAVE DANGER. WE MUST DO SOMETHING, AND WE MUST DO SOMETHING QUICKLY, BECAUSE THE POLICIES OF THE CURRENT ADMINISTRATION THREATEN THE ACHIEVEMENTS IN HEALTH FOR WHICH WE HAVE ALL LABORED FOR DECADES.

IF WE DO NOT WORK TO INSURE THE SURVIVAL OF OUR HEALTH CARE SYSTEM. IF WE DO NOT WORK TO MANAGE OUR HEALTH CARE SYSTEM IN AN APPROPRIATE WAY, I CAN ASSURE YOU THAT THERE WILL BE NO HEALTH CARE SYSTEM IN THE FUTURE.

OVER THE LAST THREE YEARS OUR INSTITUTIONS AND THE PEOPLE THEY SERVE HAVE BECOME ANEMIC AS THEIR FINANCIAL LIFE BLOOD HAS SLOWLY BEEN DRAINED FROM THEIR SYSTEM. SOME OF THEM ARE NOW SEVERELY CRIPPLED, BARELY ABLE TO BREATHE, AND ARE NOT IN A POSITION TO WITHSTAND ANOTHER SHOCK. HEALTH INSURANCE FOR THE UNEMPLOYED IS AN ABSOLUTELY NECESSARY TRANSFUSION. FOR WITHOUT IT, OUR HEALTH CARE SYSTEM, ALREADY FRAIL, WILL RAPIDLY BLEED TO DEATH.

THANK YOU.

Senator QUAYLE. Thank you, Dr. Shapiro.

Dr. Blankenbaker, on page 2 of your statement, you mention a 30-percent reduction in physician visits. Do you believe that that indicator shows that there is a relation between in the number of physician visits and the loss of health insurance? Do you believe that there is a correlation there?

Dr. BLANKENBAKER. That is not a scientific study. It is a fact that I have heard from many physicians, that their practices are down some as much as 30 percent, and they allude to the fact that it is the unemployment situation that is keeping their patients away from their offices. I am not aware of there being any kind of statistically significant study, though, that would actually support that statement.

Senator QUAYLE. The last panel ended up agreeing with the assessment that the problem is not necessarily the emergency situation, because that is going to be taken care of in the emergency room; if someone needs an appendectomy, he is going to get it. But the problem is the preventive care, including the prenatal and postpartum care. Do you agree with the conclusion that the real problem we are beginning to see is that people are just reluctant to make that visit to the physician because of the lack of this coverage? Is that a fair conclusion that we could reach?

Dr. SHAPIRO. It is a very fair conclusion. If I may, for just 20 seconds, take an example, I heard about a 6-year-old child who had asthma. The father lost his job. The child would have frequent attacks. When we had them, the parents were very alarmed and would take the child to the emergency room or to the doctor. What has happened now since they have lost their health insurance. The father is afraid that during the flu season, during the winter season, that the child would get an asthmatic attack. The family could not afford the stabilizing medicine, so the father kept the child home from school, so the kid would not get sick, so they would not have to go to the emergency room, which they could not afford. So, not only did we have no preventive care but we also had a 6-year-old whose dad kept him out of school. We are seeing this all the time. People are delaying mental health services, drug and alcohol services, prenatal services, and hypertensive services. And

it is not just the unemployed. We have a health care system that needs money. Hospitals are being forced into a demarketing position. We just need the infusion of enough money so the system can hold together until and when we have necessary reform. We are seeing it, and we have data on it, which I would be glad to submit to this committee.

Senator QUAYLE. I would appreciate that.

Let me ask just one other question of the two panel members. Given the fact that we are talking about just health insurance for the unemployed, and not getting beyond the other aspects of our health system, and given the fact that there are certain restraints within the budget, what would you recommend that we do, given the further fact that the Congress will do something? What should we do, and perhaps, what shouldn't we do?

Dr. BLANKENBAKER. One of the things that I think definitely needs to be done is to get a better hold on exactly where the problem is. I would guess that, from what I have heard, that something definitely is going to be done. And I think what you have heard this morning is that, if we are not careful, we will be putting money into the areas that are already being cared for, and we will be missing the routine, prenatal visits, the early-on visits, the preventive care that would be more cost-effectively used to prevent the critical needs, which are much more expensive.

So I guess from my standpoint, I would hope that we continue to study the problem, try to seriously understand it better and what difficulties it is creating for our health care, and then, if money is placed into the service of care to these individuals, that at least a significant amount of it be allowed to be used for that care that will be in the area of prevention of those more expensive costs.

Senator QUAYLE. Dr. Shapiro.

Dr. SHAPIRO. I think the issue has been studied and overstudied for the last two decades. I think there are solutions; we know what they are. They are cost control, quality control, limits on expenditures and guaranteed benefit packages, which as has been shown time and time again, will cost us as a health care system and as a Federal budget over 4 or 5 years, less money. But until we get to that point—it is not going to happen in this Congress, I do not believe; maybe in the next, but not in this one—that we need to address the problem.

I disagree with the basic premise of your statement, and that is that the budget limitations are there, yes, but I hope that the Congress will, in fact, bite the bullet and say, "We do not have to eliminate all of the health programs before we eliminate some of the waste in military spending," and that in fact, there can be bipartisan support for health and human services in this Congress.

Senator QUAYLE. Well, what I was trying to do was to focus on precisely that this committee is going to be doing in the next couple of weeks. This committee is not going to have any trade-off on defense spending versus health care costs. This committee is going to be focusing on what we ought to be doing for the unemployed, and that is what I was trying to get at, and that was the basis of the question. I know these others are a problem and a concern, and as a matter of fact, we can talk about them at another time, but specifically what we are calling this committee for and

what we are going to try to do is what should we be doing for the unemployed.

Dr. SHAPIRO. I would say a \$1 to \$2 billion targeted program, administered by State and local governments, with a well-defined benefit package that states a minimum, does not let the States just rip off the money and design a program in any way they want, but that it should be one that goes far enough to outline a minimum benefit package that must be there, that does have cost control, and it is the beginning of putting leverage on a health care system for future changes.

Senator QUAYLE. Senator Metzenbaum.

Senator METZENBAUM. I am going to waive my question.

Senator QUAYLE. Senator Kennedy.

Senator KENNEDY. Just briefly, Dr. Shapiro, you talk about "demarketing services." We know what marketing services means. What is "demarketing services"?

Dr. SHAPIRO. Demarketing, Senator, is when a person calls up for a clinic appointment and says, "I'd like to come in to be examined, because I think I am pregnant," and the hospital says, "You have to talk to our financial counselor." And then the person talks to him and is told that unless he or she brings in \$1,000 or \$100 or \$300, they will not be seen. It is putting in longer waiting lines, it is cutting down some of your clinics, it is selectively marketing to those who have the ability to pay, and we are seeing this in Philadelphia today.

Senator KENNEDY. Are there hospitals now in Philadelphia that require up-front money in terms of delivery of babies?

Dr. SHAPIRO. There are more than one hospital that will not see you in their clinic without putting up an up-front deposit if you do not have health insurance.

Senator KENNEDY. Dr. Blankenbaker, you mentioned on page 2, "Some doctors report their patient visits are down as much as 30 percent." Does that mean that they were getting unnecessary care before they—

Dr. BLANKENBAKER. I do not think so. I think that it means that patients are placing priorities on when they are going to see the physicians, when they are going to the hospital, and so forth, and I think unfortunately, they are cutting out those that are in the area of routine, preventive measures that might keep them from having to go to the hospital.

Senator KENNEDY. I think that is important. I think that is a helpful response. So you believe that that reduction is in the areas of preventive services that are important?

Dr. BLANKENBAKER. Yes. These statements were made in terms of out-patient office visits, which are generally the daily, routine, preventive-type measures, along with episodic ambulatory care.

Senator KENNEDY. Thank you.

I have no further questions. I would hope that those wonderful baby noises we are hearing from the back of the room are from another witness, that we might have an opportunity to hear from them at some early time. I suppose it is getting near their lunchtime, as well as others, but I will leave that, obviously, to the Chair.

Thank you very much.

Senator QUAYLE. Thank you, Dr. Shapiro and Dr. Blankenbaker. The next panel, we are going to go to Mr. John McCormack of Baltimore, Md., Mrs. Anna Sloan, Mr. Nichlos Contos, and Jim and Laura Johnson, from Springfield, Ohio.

Senator KENNEDY. Mr. Chairman, I thank you for adjusting the witness schedule to accommodate some of these individuals. And I appreciate the patience of our next witnesses, as well.

Senator QUAYLE. OK. On my list first is Mr. McCormack from Baltimore, Md.

Mr. McCormack.

STATEMENT OF JOHN McCORMACK, BALTIMORE, MD.; ANNA SLOAN, TURNERS FALLS, MASS.; NICHLOS CONTOS, FLINT, MICH.; AND JIM AND LAURA JOHNSON, SPRINGFIELD, OHIO.

Mr. McCORMACK. Yes, sir, I have been laid off since February of 1982.

Senator KENNEDY. Would you just bring the mike a little closer, please.

Mr. McCORMACK. I am not used to all of this.

Senator KENNEDY. We want to make sure that a few million Americans hear your story, as well, because they might be able to identify with it.

Mr. McCORMACK. Yes, sir. I have been laid off from Bethlehem Steel since last February 1982. My benefits have been exhausted since August 1982. My daughter had an acute case of tonsilitis; her adenoids have to be removed, and she has to have two drains put in her ears. I went to several hospitals, and I was denied anything; everything, I was denied, because I did not have any benefits or coverage. They asked for an enormous amount of money to be put down before my daughter could go into the hospital. I could not afford it; being on \$153 per week for unemployment benefits, I cannot afford that.

I went to several doctors. You asked the question, Senator Quayle, whether anybody has been denied any kind of benefits. Yes, they have been denied at the hospital. I am one, and my daughter is one who has been denied going to the hospital for this.

I found one doctor who would take my daughter, but on the basis that I would pay him later, as I can. So that is what I have been doing right now.

I don't know what else to say.

I have been denied everything. Food stamps—I went as far as to go to the medical assistance program that we have in Baltimore City and County, and I was denied that because my pay rate of my unemployment benefits was too high for me to be eligible for this. I just did not know where to turn to at all; I still do not know where to turn.

My daughter is still home. She has lost many days in school because of this. It just seems like nobody wants to help. So I think this package here, to help the unemployed steelworkers, any unemployed people in the United States, would definitely be a help.

I guess I am just a small percentage of those, but I hope I am speaking for a lot of people from United Steelworkers.

Senator QUAYLE. Thank you very much, Mr. McCormack.

I think we will go ahead and listen to the rest of the panel and then open it up for questions. Just feel very comfortable. Just pull the microphone in and tell us your particular story, things that you think that can be done. We would be interested not only in your own personal story, like Mr. McCormack has told, but you may know of other stories of some of your friends and neighbors, people who are unemployed right now who are having a problem receiving proper medical attention, and this is of great interest to the committee, so feel relaxed—we are relaxed—just speak right up. You did very well, Mr. McCormack.

Mrs. Sloan.

Senator KENNEDY. Mrs. Sloan is from Massachusetts, Mr. Chairman, and we want to welcome you here, Mrs. Sloan.

Mrs. SLOAN. Good morning, Senator Kennedy.

This is my second time through the unemployment process. I have been laid off since May 1982. I am the mother of five children. I am also a widow. My husband died in 1976, and at that time, he was unemployed; previous to his illness, he was unemployed in December 1974. He was ill through 1974 and 1975, and died in 1976. So I am going through the whole process again, in that my family has no medical insurance.

Out of my five children, my 16-year-old daughter has a form of arthritis which we have been to an arthritis specialist, which costs \$99 a visit. And when you are getting \$164 a week to support six people, that does not leave any money for an arthritis specialist, let alone a regular doctor.

I am very conscious of my children's nutritional needs, and so far, other than her medical expenses, the other children have been healthy so that we have not needed any hospitalization type of coverage.

I don't know what else to tell you. It is a very scary process. I am terrified all the time that something will happen to one of my children, and I will not have those benefits there.

That is all I can say.

Senator QUAYLE. Thank you very much, Mrs. Sloan.

Mr. Contos.

Mr. CONTOS. I would like to say, before I start telling you what happened to me, I want to thank Mr. Kennedy for sending me here. This is the first time I have been in Washington. And I thank everybody for being here. I hope we can get something done for all American people and not just for myself.

I am like everybody else. I have been laid off almost 4 years now. I was working at construction. I lost all my benefits, everything. I am living on \$146 per month on two land contracts—what I inherited from my father's estate, plus I own four pieces of property, so I was denied medicaid and medicare.

So it gets kind of disgusting when you have to go to the hospital. I just became a new father about a month ago. I had a little daughter, named Melissa May Contos. She was a premie; she was 7 weeks early. And I know all about the medical costs, because it is costing me about \$1,000 a day for her to be in there. She is home now, but that is what it is running. I just do not have any insurance to pay for it, and the hospital knows this, and like I said, I have been denied medicaid, and thanks to some of my relatives and

people and friends who have been helping us out, we will try to ride this out.

But like I say, her bill is going to be about \$60,000 when it is through. I have no way of paying for this. That is what I have got to contend with every day, wondering where am I going to get the money to pay it. There is no way. My wife is unemployed, and she still had medical problems with her kidneys before she had this baby. We almost lost both of them on account of this. We were denied in the hospital three times. They refused because we did not have the money, \$3,000.

We just did not have it. If it was not for the doctor that we knew there, he insisted on her to go in there, and he put us in there. That is the only way we got in was on account of one doctor who helped us out. Otherwise, we would have been denied all over. And that is where it is at right now. She is home now. My wife is doing fine. The baby is doing fine. But if something were to happen to her now, there is no way I could put her in the hospital, because I cannot afford to pay for it.

So I hope that Congress—and I am speaking not just for myself, but for all the unemployed in this country—we need some kind of program to help all the unemployed, not just for myself, but for everyone. And I am hoping that Senator Kennedy, Senator Quayle, and Senator Metzenbaum, we can do something to help these people, because this country has got money for everything else but to help the people in this country. It is about time we looked out for the people in this country. We have a war going on down in El Salvador, and we are spending all that money down there when it should be right here in this country for the unemployed workers.

That is my testimony, and I thank you for being here today.

Senator QUAYLE. Thank you very much, Mr. Contos.

Mr. and Mrs. Johnson.

Mr. JOHNSON. I was laid off from the Coca-Cola Bottling Co. in June 1982. One week later, I found out my wife was pregnant. So I went to my insurance company, and they refused anything at that time. So we went to welfare 1 month before the baby was born, and the midwife where she went to the doctor who delivered her, said that the welfare would pay for it if I was still laid off. So we went there 1 month before the baby was due, and they told us to come back afterward, and they still just—"No way," they said.

So now, the baby has got to be on this monitor all the time; it is an apnea monitor. She quits breathing. I do not know what causes it, and the doctors do not know what causes it, but we have \$7,000 worth of hospital bills right now, and there is just no way I can pay it, being laid off.

The hospital has not ever refused me. We really do have a very understanding doctor. We have never paid him anything. I know he is getting tired of it, and so is the hospital. There is not much to say, but I know there is no way I can pay all these bills. If I had a job, maybe I could, but there just are no jobs out there.

I don't really have much more to say.

Senator QUAYLE. Mrs. Johnson, do you have anything you want to say?

Mrs. JOHNSON. No.

Senator QUAYLE. Well, I want to thank each one of the members of this panel. Each one of you in a way shed light out a different type of problem that we see confronting us. I believe that your testimony dramatizes the human aspect of the problem that we are facing. So often here in Congress, it is easy to get caught up talking about particular bills, and what the level of funding is going to be, and what committee jurisdiction it is going to be, but I think that your testimony and the fact that you would come here today and share that with us is certainly going to be very valuable for this committee as we go forward. And I can only say that the members of this committee, and I believe the Congress as a whole, really have a sensitivity for the problems of the unemployed. Mr. Johnson pointed out, "If I could just have a job," that means you usually have good insurance coverage, or better insurance coverage than what you have right now. That is what we are all striving for.

These hearings, as I said before, are related just to discuss the health benefits aspect. I think Mr. McCormack made the point, and it was emphasized by Mr. Contos, as well, that people are being denied health coverage. Mrs. Sloan indicated the problems in her particular children and her family. I am sure that your cases are not isolated cases, and that there are many other cases around the country, and this is just simply the tip of the iceberg. And I for one, and as chairman of the committee, will be moving forward in the spirit of bipartisanship, trying to help people out and find the best answer for this. I am deeply indebted to each one of you for your testimony. I know that at times you may feel a little bit nervous, but each one of you added a considerable amount of value to the testimony we have heard already, and we will hear some more this afternoon.

I thank you very much for your coming here, sharing your stories with us.

Senator METZENBAUM.

Senator METZENBAUM. I, too, want to thank each of you. I know it is not easy to testify before a Senate committee, particularly about some of the problems that you have experienced on a day-by-day basis. I know something about the problems of the Johnsons. As I understand, Mr. Johnson, you had a job in Springfield, and your wife also had a job in Springfield—she worked for the chamber of commerce, as a matter of fact, didn't she?

Mr. JOHNSON. Yes.

Senator METZENBAUM. You both were laid off, and you got another job, Mr. Johnson, in Dayton?

Mr. JOHNSON. No. I went up there for 4 days. When they closed the plant down, they told us if we went to Dayton that we would have a job. I went to Dayton for 4 days, and the union man came up, and he just said, "You can take your unemployment. We will sign the papers." And he told me to go ahead and leave.

Senator METZENBAUM. So you did not have a job, then?

Mr. JOHNSON. No.

Senator METZENBAUM. Now, the baby stops breathing at certain times, I think you told me; is that correct?

Mr. JOHNSON. That is right, yes.

Senator METZENBAUM. And you have a piece of equipment in front of you. Is that called an apnea device?

Mr. JOHNSON. Right. It is an apnea monitor.

Senator METZENBAUM. And how does that equipment work?

Mr. JOHNSON. If her heartbeat falls under 80 beats a minute, there is a noise which lets us know that her heart is not beating, or if she quits breathing for any length of time like for ten seconds, it goes off, also.

Senator METZENBAUM. And has that happened?

Mr. JOHNSON. Yes.

Senator METZENBAUM. The baby is 2 months old, and how often has it happened so far?

Mr. JOHNSON. It happens about once a week, probably.

Senator METZENBAUM. About once a week?

Mr. JOHNSON. Yes.

Senator METZENBAUM. And when the baby is sleeping, that machine must be attached to her?

Mr. JOHNSON. Yes, right.

Senator METZENBAUM. And how much does that machine cost, and where do you get it?

Mr. JOHNSON. I got it from Med-Air Professional Services, and it costs \$200 a month.

Senator METZENBAUM. And how are you paying the \$200.

Mr. JOHNSON. I ain't.

Senator METZENBAUM. You ain't.

Mr. JOHNSON. No. I haven't got the money. I have just been holding them off as long as I can.

Senator METZENBAUM. And at some point, if you do not get the money to pay for it, the machine has to go back?

Mr. JOHNSON. I am sure, yes, right.

Senator METZENBAUM. Has there been a history of crib death in your family or your wife's family?

Mr. JOHNSON. Yes, both. My sister and my wife's mother both had infants who died of crib death.

Senator METZENBAUM. Laurie, have you been trained recently to give cardiopulmonary resuscitation because of the baby?

Mrs. JOHNSON. Yes, I was taught when she was 3 weeks old how to do it.

Senator METZENBAUM. I have no further questions.

Senator QUAYLE. Thank you, Senator Metzenbaum.

Senator Kennedy.

Senator KENNEDY. Thank you very much, members of the panel. I just have a few questions.

Mr. McCormack, you had worked for a period of 10 years, as I understand, before you lost your job as a crane operator with Bethlehem Steel; is that correct?

Mr. McCORMACK. Yes, sir, that is correct.

Senator KENNEDY. And you enjoy working, and you are eager to go back to work; is that correct?

Mr. McCORMACK. Yes, sir, yes, sir.

Senator KENNEDY. And you lost your job and have been unemployed, and even after you lost your job, you tried to get some odd-jobs over the period of time; is that right?

Mr. McCORMACK. Yes, sir.

Senator KENNEDY. And what is your income now?

Mr. McCORMACK. Well, my wife works at Epstein's, and she brings home approximately \$70 to \$75 a week—that is after taxes—and with my \$153 a week from unemployment.

Senator KENNEDY. Now, do you have some expenses? Do you have an automobile?

Mr. McCORMACK. Yes, sir, I have an automobile. I had to sell my 1974 Toyota in order to pay some bills. Then I bought a 1972 Nova for \$300.

Senator KENNEDY. So you could go around and look for some other work?

Mr. McCORMACK. Yes, sir, that is correct.

Senator KENNEDY. And do you have auto insurance that is due on that?

Mr. McCORMACK. Yes, sir. My auto insurance is due—well, it is past due now. It is almost 3 weeks behind.

Senator KENNEDY. Do you have some taxes on your home?

Mr. McCORMACK. Yes, sir, my property taxes run approximately \$900 a year.

Senator KENNEDY. Are you up-to-date on those taxes?

Mr. McCORMACK. No, sir. We have been making payments on the property taxes since I have been laid off, and I owe \$48 or \$49 balance due by the end of April, which I could not pay for.

Senator KENNEDY. Are you concerned about that, whether you might lose your home?

Mr. McCORMACK. Yes, sir, I am. I even asked my mother and my mother-in-law—thank God, I have a mother and mother-in-law—they have been helping me out quite a bit, and I am fairly deeply in debt with them.

Senator KENNEDY. You have had life insurance over a period of years so that you could provide, I suppose, some security for members of your family, because you have three children; is that right?

Mr. McCORMACK. Yes, sir.

Senator KENNEDY. What is happening to that?

Mr. McCORMACK. Well, I have two life insurances, sir—one with Sun Life, which my wife has had since she was little, and Monumental Life, which I do not have a copy of that there; I left it at home. They run—one is something like \$27 a month, and the other one is \$30, \$32 a month.

Senator KENNEDY. And you are about to lose those, are you not, because you cannot keep up the payments; is that correct?

Mr. McCORMACK. Yes, sir, I am.

Senator KENNEDY. Is there a mortgage on your house?

Mr. McCORMACK. Yes, sir, the mortgage on the house is \$290 a month. I am approximately a month and a half behind on that now.

Senator KENNEDY. What does all that add up to?

Mr. McCORMACK. My calculations—well, that is not including the other bills, either; that is not including the gas, electric, telephone, water bill, and if you have to make payments like I have to on my property taxes—

Senator KENNEDY. And I suppose the children like to eat, too, don't they?

Mr. McCORMACK. Yes, but I have been denied food stamps. My wife and I, they considered that we were \$96 over our limit. And I

cannot see anybody—if they can feed five people on \$96 a month—you cannot do it.

Senator KENNEDY. Now, the cost of this operation, as I understand it, has been estimated to you between \$2,500 and \$3,000; is that right?

Mr. McCORMACK. That is correct, sir.

Senator KENNEDY. And you decided to defer that because of the financial situation.

Mr. McCORMACK. Yes, sir.

Senator KENNEDY. Do you think that will be the straw that broke the family's back, so to speak, in terms of your financial situation?

Mr. McCORMACK. Yes, sir, I do. I even went to Medical Assistance, and they denied me, too, because they said I was \$96 over their current scale. So I am caught right in the middle. Either I make too much money, or I do not make enough money. It is all up to them, I suppose. I do not know.

Senator KENNEDY. Let me ask Mrs. Sloan—you had worked for a number of years, had you not, before you were laid off last May?

Mrs. SLOAN. Yes. I worked 4½ years.

Senator KENNEDY. And actually, you were entitled to the widow's benefits, like retirement benefits, and you actually gave those up in order to go back to work to provide for your children.

Mrs. SLOAN. Yes, I did.

Senator KENNEDY. So you, like the other members of the panel, want to work, are ready to work, eager to work, but unable to work, given this economic climate that we find ourselves in. Around the area of Turners Falls, it is about a 10-percent unemployment level, is that about right?

Mrs. SLOAN. Yes.

Senator KENNEDY. It is difficult to find a job up there. Now, do I understand correctly that, given the fact that you have these other children, and the amount of income you have to provide for those children, that your daughter has given up seeing the arthritis specialist because of the limitations on your income and because of what you consider to be your responsibility to your other children?

Mrs. SLOAN. Yes, we have.

Senator KENNEDY. Is that so?

Mrs. SLOAN. Yes.

Senator KENNEDY. And now, as I understand, your daughter has stopped seeing the specialist, and do I understand correctly you have also stopped giving the medication that was prescribed?

Mrs. SLOAN. She has taken the last of it, yes.

Senator KENNEDY. She has taken the last of her medication. And you moved her to a diet for arthritis, is that right?

Mrs. SLOAN. Yes, we are.

Senator KENNEDY. Where did you get the diet for arthritis?

Mrs. SLOAN. We are seeing a holistic doctor, who has given us a diet that has been successful with other arthritics.

Senator KENNEDY. What does this mean—what does this mean to you in terms of your concern for the bringing up of your children? I mean, every morning, every night, every day, what does this mean to you in terms of your own view about the future and their future?

Mrs. SLOAN. Well, I fear that something will happen. My fears and my tensions, whether spoken or unspoken, tend to rub off on my children, which causes more problems. If I am afraid, they feel it, they sense it, and it just causes that many more problems. We have to make choices on when we see a doctor and for what reason. If it is a simple sprain, we have to administer to it ourselves, and if it is more serious, then we have to see a doctor. But those choices are very hard to make.

Senator KENNEDY. It must make your life extremely difficult.

Mrs. SLOAN. Yes, it does.

Senator KENNEDY. And the children's lives?

Mrs. SLOAN. Yes.

Senator KENNEDY. And one of the reasons, obviously, is because of these medical bills which draw so much on your income.

Mr. Chairman, I just have one final question to Mr. Contos. Did I understand correctly that you said that when your wife became pregnant, the hospital that you went to wanted \$3,500 up-front?

Mr. CONTOS. That is right, sir.

Senator KENNEDY. And you could not pay it, so you shopped around and found a clinic that had a program for \$800 that would cover prenatal care and delivery, plus 24 hours in the hospital after the delivery, and if there were any complications for either the mother or the baby, it would be terminated; is that right?

Mr. CONTOS. That is right.

Senator KENNEDY. Were there complications?

Mr. CONTOS. Yes, there were.

Senator KENNEDY. And what happened?

Mr. CONTOS. They had to keep my wife in the hospital for a week on a dialysis machine on account of her kidneys. It was that, and then they found out she had too much protein, so the doctors said, "Well, we may lose her, or we may lose the baby. We have to go in and get her out now." So they went in at about 10:30 Wednesday night, April 30, and they gave her a C-section, they pulled the baby out, and the pressure went down—and the heart pressure was up there, too, plus her blood pressure—and the baby was normal. Thank God for that. She was coming out screaming like mad, so we knew she was all right. But she was in the recovery room for about 2½ days before she finally came out of the recovery room.

Senator KENNEDY. Now, was that covered by the \$800?

Mr. CONTOS. No, sir.

Senator KENNEDY. So, how long do you think you will be continuing to pay off that medical bill?

Mr. CONTOS. You are going to laugh when I tell you this, but when my wife talked to one of your representatives, she kind of laughed. She said, "There is no way. We do not have it. There is no money there."

Senator KENNEDY. You would be paying off a few dollars a week, probably, for the rest of your life.

Mr. CONTOS. That is right. It could be, if we do not get any kind of assistance. Other than that, we may have to file for bankruptcy. That is the only way.

Senator KENNEDY. Well, has the hospital said, "Do not worry about this. We will work it out"?

Mr. CONTOS. Well, they are trying to get us on these programs, but so far, we have been denied, because I own some property.

Senator KENNEDY. The only point—and I will, Mr. Chairman, close with this—we have heard from the representative organizations here this morning that really wonder whether there is a problem in this country. You heard from the spokesman from the American Medical Association who said there is some problem, and he hopes there will be some action. You heard from the hospitals, who have said, "There is some problem, and we hope there will be some action." We hear from other panelists who have said, "Look, we really do not know the numbers. We know there is some misery. We need more study, we need more information. We hope the Congress will not act hastily, because we really do not know what the dimensions of this issue and this problem are."

We have heard this morning from this panel, from men and women who have worked over their lives, who have made this country the great country that it is. Their primary concern is their children and what is happening to their children. Because they are not able to work, they must deny their children the decent quality health care which this country is capable of providing. When we hear of a young child now, about whom all the doctors say, "You ought to get her tonsils out," or a young girl who is in serious need of treatment for arthritis, and the parents, who are caring and loving, feel that they are caught in a trap and are not able to deal with those kinds of needs, I would hope that this would be a very clear message to the Congress that we should get about the business of acting, and acting in a meaningful way to deal with these problems.

I want to thank all of you for coming here and sharing your stories with us, and I would just give you the assurance that there are many of us on this committee who are going to do everything we possibly can to at least make some difference. We cannot solve all of these problems, but we are going to do our best, and I think that is the only way that we can express our appreciation for your presence here this morning.

Thank you.

Senator QUAYLE. Thank you, Senator Kennedy.

I would like to welcome Senator Riegle and call on him for any comment. We are, Senator, trying to operate within the 5-minute rule. We have three more panels, and I would like to get out of here by 12:30.

Senator Riegle.

Senator RIEGLE. Thank you, Mr. Chairman. I understand.

First of all, I want to say to you, Mr. Contos, that I am especially pleased that you are here on this panel, coming as you do from Flint, Mich. Is it fair to say that in Flint, there are literally thousands of people in exactly the same circumstance you are?

Mr. CONTOS. I can say for myself, like we talked about a while ago, financially, I am not so bad. Like some places I would go to get help, they would say, "You are in better shape than most people here in this town." I say, "Yes, but I hate to beg for something. I am always used to working all my life, and I have to come down here and beg." She said, "You are not begging. You are asking for help."

I said, "Well, to me, that is begging, because I have worked all my life."

Senator RIEGLE. But you have been unemployed the last 3 years?

Mr. CONTOS. Right.

Senator RIEGLE. And your family is a well-known family in the Flint area and enjoys a very fine reputation, and has for many years. But the situation, it seems to me, that you are describing is one where literally, tens of thousands of people in our own community of Flint are in exactly your circumstances.

Mr. CONTOS. That is true.

Senator RIEGLE. They want to work, they have worked for years, and are now not able to find work and are faced with these medical costs and medical emergencies that they just do not have the money to pay for.

Mr. CONTOS. That is true.

Senator RIEGLE. And even if you own a piece of property, and I understand you do, that does not mean you can sell it today in Flint.

Mr. CONTOS. That is right. I have had it up for 3 years, and I cannot sell it.

Senator RIEGLE. So that kind of a measure of a person's situation is not necessarily very useful in the condition we find ourselves in.

Let me ask you this. What have these pressures and concerns done to your own health?

Mr. CONTOS. My health? I am a diabetic, plus I am hypertensive, too, and I have pills I have to take, and when they run out, I just do not have the money to go and buy any. I look after my wife and my child right now. They come first. I let myself go.

Senator RIEGLE. Some people talk about voluntary efforts by doctors. As you look at your experience, and as you look at the experience of other unemployed workers in Flint and in Michigan, have you noticed that people's medical needs are being met on a voluntary basis by people in the medical community?

Mr. CONTOS. Well, I cannot speak for the community. I suppose there are some. But I know with my doctor—thank God I have a good doctor—he does not charge me anything, but it is just the idea of going to this man, but he knew my family for a number of years, and I am thankful for that, that he does give me some kind of medical help.

Senator RIEGLE. But I mean, in your case, you have that degree of advantage, in that your family is well-known, and your doctor may be helping in your case. But do you know of other workers in the area who are finding that they cannot get medical treatment?

Mr. CONTOS. Yes. My brother is the same way. He does not have any insurance. He lost his business. And he is an alcoholic, but he is trying to recover, and he is having a rough time of it, too.

Senator RIEGLE. Let me just ask all of you, what do you think the country ought to do at this point, when people like yourselves, who are just typical Americans, when you are caught in this situation out there—you all want to work; you are unemployed because there are not any jobs to be found; you have serious medical problems, and you have no medical insurance to help you meet those problems for yourselves and for your families—does the country have some obligation?

Go ahead.

Mr. McCORMACK. Yes, sir. My personal view—I do not know how the others feel, but as far as I am concerned, I think we ought to stop sending money out of the country and start putting some money into this country. That is the way I feel.

Senator RIEGLE. Well, it seems to me that if we are not willing to invest in our people, and if we are not willing to keep our people healthy and able-bodied, that we have really missed the most important priority in the Nation; that our people are really the great gift of this Nation. It is not the physical resources, as such; it is the human resources. And it seems to me that any of us could be sitting in your seats today. You happen to be there because you are caught in this dilemma. But you really are here representing 12 million Americans and their families who are caught in circumstances that you really had no part in creating. And I think we do have an obligation to respond, and I think the administration has an obligation to respond—and that is not to simply say that there is a problem and it would be nice if somebody did something about it. I think we have to be prepared to use some resources. I think we have to be prepared to use some money, to see to it that emergency medical help is available to everybody in this country who needs it and who otherwise cannot afford it, and very particularly, to unemployed workers, who have given years of work, in some cases decades of work, of hard work in the work system, contributed to the country, have paid taxes, and now are in a situation where, when you face desperate medical problems, are really told that there is no one there to help. I do not think that is a sufficient answer, and I think we have an obligation to respond. And we are doing everything we can here to do that. We have drafted a variety of health care bills for unemployed families. I have drafted one; Senator Dole has a proposition; Senator Kennedy has developed one, and we hope not only to act on that even this week in the Senate, in terms of providing room in the budget so that we can actually finance this kind of health care protection and coverage, but beyond that, to see that this is actually put into law so that in the future, yourselves or people in your circumstance who find this happening will know that they can have health care, will know that that will be continued even though they may be in a period of unemployment that they are powerless to correct.

So, I want you to know we are working at it, and you are not alone in this struggle. We mean to help you, we are working to help you, and your coming today, I think, is important in advancing the fight to get this kind of medical protection into place.

Senator QUAYLE. Thank you, Senator.

Again, my strong appreciation for the panel and your very valuable contributions. Thank you very much.

The next panel, I want to call from the National Association of Manufacturers, Mr. Bliss; from the Washington Business Group on Health, Mr. Goldbeck; and from the Chamber of Commerce, Mr. Ozga.

First of all, I thank the panel for allowing us to adjust the witness list. I certainly appreciate that.

Mr. Bliss.

STATEMENT OF DONALD T. BLISS, ESQ., PARTNER, O'MELVENY AND MYERS, WASHINGTON, D.C., ON BEHALF OF THE NATIONAL ASSOCIATION OF MANUFACTURERS' HEALTH SUBCOMMITTEE, ACCOMPANIED BY SHARON CANNER, HEALTH CARE ANALYST; WILLIS B. GOLDBECK, PRESIDENT, WASHINGTON BUSINESS GROUP ON HEALTH; AND JAN PETER OZGA, DIRECTOR OF HEALTH CARE SERVICES, CHAMBER OF COMMERCE OF THE UNITED STATES, ACCOMPANIED BY MICHAEL ROMIG

Mr. BLISS. Thank you, Mr. Chairman.

My name is Don Bliss, and I am with the law firm of O'Melveny and Myers, and today, I am representing the National Association of Manufacturers' Health Subcommittee, of which I am a member. Ms. Sharon Canner, who is a health care analyst with the NAM, is accompanying me today.

We wish very much to commend this subcommittee for taking the time to address what we acknowledge is a problem of serious national concern—the unemployed who have lost their job-based health insurance coverage. And we appreciate the opportunity to present NAM's views. We wish to submit our full statement for the record, which I will briefly summarize at this point.

Senator QUAYLE. Your complete testimony will be entered in the record.

Mr. BLISS. Mr. Chairman, the experience of the last few years has taught us that in addressing problems of health care financing, we must avoid the creation of new governmental entitlement programs, the establishment of new Federal or State bureaucracies and regulatory regimes, or the addition of new financial burdens on the Federal health care budget.

All too often, such well-intended programs simply fuel the flames of spiraling health care cost inflation, diffuse the concentration of limited Federal health care dollars on the truly medically needy and exacerbate the rising, uncontrollable element of the Federal deficit.

Can we really afford any new entitlement programs at this time? In today's economy, the solution to this very serious problem must be found to the maximum extent possible in the private sector, and for this reason, we believe that any Federal legislation that this committee considers should build on the existing private insurance structure and include the following elements.

First, to provide coverage for employees temporarily laid off, existing job-based group health plans should be extended for at least 90 days. This continuation of coverage would be a condition of the employer's deductibility for health benefits now provided under the Internal Revenue Code. Coverage would be maintained for this additional 90 days at the same benefit levels and cost-sharing arrangements that existed before the layoff.

Second, after the 90-day period, or a longer period if the employer so provides, a second phase would take effect. Here, the former worker would have two choices. First, he or she could continue the same coverage at a cost paid by the former worker at group rates to be negotiated with the insurance carrier by the employer; or alternatively, the former employer would have the option of purchasing a low-option, basic insurance package, which would reduce sub-

stantially the cost of coverage. The low option would include catastrophic, some hospital and physician services, but at a substantially reduced cost, and this would last for at least 1 year.

Third, in the event an unemployed worker's spouse loses a job due to layoff, the employer of the working spouse would be required to offer insurance coverage immediately upon the expiration of the mandatory 90-day continuation. Now, this will not solve the entire problem, but I will point out that 42 percent of the unemployed have working spouses, and so, this would address the problem to a substantial extent.

And fourth, unemployment reentry. To facilitate the reentry of workers to new jobs, health insurance coverage at the new place of employment should be made to become effective not later than the 31st day of employment. Currently, many employees have to wait 1 to 6 months for new coverage, which does not include preexisting conditions. We would make mandatory the inclusion of preexisting conditions and the initiation of the new coverage within the 30 days after employment, waiving such open enrollment restrictions as may be necessary to meet this objective.

Now, we believe these four steps are practical, real steps, tied to the Internal Revenue Code, that constitute a private sector approach to a very serious national problem. The principal benefit of this approach, Mr. Chairman, is its administrative simplicity in that it uses the existing private insurance structure as a basis. The vast majority of companies, over 90 percent, both large and small, provide a group health plan administered by the company or its agent. Use of this structure to assist the laid off worker would not require a new Government agency or staff. If this subcommittee, however, believes that Government involvement is needed, we would prefer the block grant approach taken by S. 811 to the other alternatives that we have looked at or considered, and have been proposed to this subcommittee and the Senate Finance and the House. The advantages of the block grant approach are that no new Federal entitlement or agencies are created, that the States have the flexibility to administer the program according to local needs, and that the program is limited to the temporarily unemployed.

Before this subcommittee recommends any new Federal program, however, we hope you will give serious consideration to the following concerns: What will be the effect of spending Federal dollars on new health care programs at a time of escalating budget deficits and spiraling health care cost inflation? What are the realistic projections for spending in the outyears? Is it fair to cut back on entitlement programs for the elderly and for the poor, who must rely on Government aid, while at the same time, creating new categories of eligible persons? Will the coverage be provided only to those who truly need it, recognizing that some unemployed persons have extended their coverage up to 2 years after layoff; some have adequate personal resources to pay for health insurance; some have coverage through working family members, and some are the beneficiaries of private, voluntary programs. What pressures will be brought to expand the program to cover other persons without health insurance—some 20 million of which are not covered by the proposals that have been presented? Or to improve the health

benefit package? And what are the prospects for economic recovery that will reduce the severity of the problem we all recognize? We all recognize that the real answer to this problem is putting the unemployed back to work. That is the best solution. And if, after review of these concerns, the subcommittee believes that further revenues for State-based programs are needed, we believe that S. 811 is the best such approach.

Thank you very much, Mr. Chairman.

[The prepared statement of Mr. Bliss follows:]

PREPARED STATEMENT OF DONALD T. BLISS, ESQ., ON BEHALF OF THE NATIONAL
ASSOCIATION OF MANUFACTURERS ON HEALTH INSURANCE AND THE UNEMPLOYED

SUMMARY

High unemployment and the corresponding loss of job-based health insurance coverage is creating complex medical and economic problems for a growing number of Americans. Other factors, including a fundamental restructuring of certain segments of American industry and large federal deficits further complicate this problem. The establishment of new entitlements or creation of additional state bureaucracies at this time is ill-advised; rather, assistance in designing a response to the medical and economic problems faced by the unemployed should be sought where the problem is occurring--in the private sector.

NAM's private sector approach calls for Congressional consideration of the the following options: (1) 90-day period. Mandated extension of health insurance coverage for laid-off workers tied to the employer's deductibility for health benefits now permitted under the IRS code; coverage must equal what is provided to other workers; (2) One year period. The option of continuing the same coverage, but with financing borne by the former worker, at group rates contracted/negotiated with the insurance carrier by the employer; or development of a "low option" (low cost) basic insurance package with financing borne by the former worker at negotiated group rates as described above; (3) Unemployment Compensation. Premium costs for additional health insurance (beyond the mandated 90 days) could be paid by the former worker out of amounts received from Unemployment Compensation; Title V of the Social Security Amendments of 1983 authorizes voluntary deductions for this purpose; (4) Spouse Coverage. In cases where an employed worker's spouse loses his/her job due to lay-off, the working spouse's employer would be required to offer immediate insurance coverage to the laid-off worker; coverage, financed by the active worker, would be comparable to that given to other spousal coverage offered by the company; (5) Employment Re-entry. Upon re-entry to a new job (or former job), health insurance coverage at the new place of employment would become effective by at least the 31st day of employment.

Mr. Chairman and members of the Employment and Productivity Subcommittee, my name is Donald T. Bliss, and I am a Partner with the law firm of O'Melvery and Myers. From 1969 to 1973, I was an assistant to the Secretary of Health, Education and Welfare. I am also a member of the National Association of Manufacturer's Policy Subcommittee on Health Care. Accompanying me is Sharon Canner, health care analyst at NAM. Today I am representing the NAM, an organization of over 12,500 corporations of every size and industrial classification located in every state. Our members employ 85 percent of the workers in manufacturing employment and produce over 80 percent of the nation's manufactured goods.

We wish to take this opportunity to commend the Subcommittee on its leadership in seeking solutions to the many problems faced by the unemployed, in particular the interest you have shown in regard to the medical/economic hardships caused by loss of job-based health insurance coverage. The NAM looks forward to working with you on this difficult, but vital task.

Private health insurance in this country covers 160 million workers and their families. Much of this insurance is provided by employers through group plans. Loss of employment often means loss of insurance coverage for the worker and the worker's family. A double digit unemployment rate results in a growing number of individuals who can no longer afford basic physician and hospital care. Naturally the pressure is growing for public action in this area.

The National Association of Manufacturers considers the loss of insurance coverage a grave problem. All of industry is affected by this problem in one way or another. When health care coverage for laid-off employees expires, these persons must of necessity seek care for themselves and their families through the publicly financed system, Medicaid. Companies that have not experienced job loss appear to be subsidizing health care for the unemployed. It is we, the employer community which supports that medical system through the tax dollar. Further, when individuals cannot cover medical bills through their own funds and/or insurance, hospitals in particular, incur bad debts and the costs are then shifted to others in private sector.

In considering the health care needs of the unemployed, the NAM has studied the various proposals that have been offered by members of Congress. These proposals have meritorious objectives and their sponsors should be applauded for their efforts to alleviate the physical and economic difficulties being faced by laid-off workers. However, proposed solutions to a complex problem must not create additional administrative or bureaucratic complexities which would stifle legislative attempts to meet the needs of citizens who are temporarily without insurance coverage. Specifically, we should not create new entitlements, expand existing programs, establish 50 individual state programs or pools. Rather, assistance in resolving this problem should be sought from those in the private sector.

If it appears likely that Congress intends to legislate health care coverage for the unemployed, the NAM has prepared a set of considerations that might assist in development of such an effort. Certain basic elements are also included in this private sector approach. Additionally, we have commented on S. 811, the block grant proposal introduced by Senators Spector and Heinz, to provide health insurance coverage for the unemployed.

CONSIDERATIONS

- o The National Association of Manufacturers believes that adequate health care should be available to all legal residents of the United States at reasonable cost. Portions of our population, at one time or other, will lack sufficient medical coverage and some of these gaps can be filled by the extension of private sector plans, while others such as coverage for the poor and near poor are legitimate areas of government responsibility, such as Medicaid. Individuals involuntarily and temporarily separated from their jobs belong to the former group and are not appropriate areas of government responsibility.
- o The loss of jobs and corresponding loss of employment-based health insurance is both a current problem requiring action and may be a long term problem requiring additional measures.
- o Any health care plan to aid the unemployed should seek to meet temporary basic primary care needs. Aid of this nature must not interfere with the individual's continuing the job search and return to the workforce.

o Health insurance for the unemployed should seek to continue the traditions by which medical care is provided to other portions of the population by offering alternative health care options. Appropriate coverage will assist the individual during this critical period of transition and furnish the support needed to continue the job search.

A PRIVATE SECTOR APPROACH

With these considerations in mind, the NAM recommends the following approach to meeting the health insurance needs of unemployed workers should legislative options be entertained.

Extension of Benefits. The starting point for this private sector approach is the existing job-based group health plan. At present, many companies offer former workers extended benefits ranging from one month to two years depending on length of service and the particular industry involved. Therefore continued coverage for a period such as 90 days could be mandated and tied to the employer's deductibility for health benefits now provided under the IRS code. Coverage given under this approach would maintain the former employee's coverage and thus would be comparable to that which is provided for other workers. The expense would be borne by the same arrangements that existed before lay-off, i.e., totally employer paid, or combined employer/employee financed.

Beyond the 90 day period a second phase would then take effect. This phase, effective for one year, would offer the former worker several choices:

- (a) The option to continue the same coverage, but with the cost paid by the former worker, at group rates contracted/negotiated with the insurance carrier by the employer (special arrangements would be made for self-insured companies).
- (b) Development of a "low option" basic insurance package with financing arrangements the same as (a). The intent is to give the individual (and family) basic protection at a minimal cost.

Unemployment Compensation. Title V of the Social Security Act Amendments of 1983 provides, at a person's request, for deduction of portions of Unemployment Compensation to finance health insurance. Those unemployed who voluntarily allow for a deduction from the UC benefits check could have those amounts used to cover premium costs as mentioned above under "extended benefits." However, we believe that this election should be totally voluntary and would oppose any mandated diversion of monies from the UC trust funds to finance health insurance coverage. In previous testimony before Congress, the NLM has opposed any diversion of monies from UC benefits for purposes other than as intended by UC law.

Family Coverage. In the event that an employed worker's spouse loses his/her job due to lay-off, the employer of the working spouse would be required to offer insurance coverage to that individual immediately upon expiration of the 90 day period. The premium financed by the active worker for this family coverage should be comparable to that charged for similar family coverage offered by the company.

Employment Re-entry. To facilitate re-entry of workers to new jobs, (or former jobs), health insurance coverage at the new place of employment could be made to become effective by at least the 31st day of employment. Special open enrollment or other timing restrictions should be eliminated under these circumstances.

HEALTH CARE FOR DISPLACED WORKERS ACT OF 1983

Mr. Chairman, I would now to comment on S. 811, The Health Care for Displaced Workers Act of 1983. Introduced by Senators Spector and Heinz, this bill would provide block grants to states for the purpose of furnishing health care benefits to unemployed workers. Discussion of this proposal today underscores the concern of this Subcommittee and others in Congress in finding solutions to this perplexing problem.

The use of block grants, as defined in S. 811, includes a number of elements which we believe have merit. States would have the flexibility to administer the program according to local needs, no additional federal agencies or entitlements would be

created, and the parameters of the proposal appear sufficiently limited in addressing the temporary unemployed as opposed to broader groups not covered by Medicaid and other public health programs.

This bill however, as with other proposals that have been presented, would require additional federal appropriations to cover program costs. At the moment this nation is experiencing escalating budget deficits with a corresponding retrenchment in entitlements and social program spending. Any attempt to create a new program would appear to be inequitable, particularly to the poor and elderly who already have been asked to accept cuts in Medicaid and Medicare. With recent signs that the economy is rebounding, it seems particularly ill-advised to exacerbate deficit spending and fuel inflation once again.

While S. 811 is time limited, set to expire at the end of 1986, it is always politically difficult to "take away" a program once it is underway. As members of this Subcommittee, I am sure you are well aware of this fact.

Against this backdrop of an improving economy, the NAM will continue to monitor and assess the problems created by the loss of job-based health insurance and measures to address this situation. Such an assessment must by necessity reflect our varied membership, which includes over 12,500 corporations of

every size and industrial classification. The broadness of our membership may also be reflective of the varied degree by which unemployment has struck certain segments of this nation's economy.

In summary, we believe that the block grant approach as described in S. 811 offers certain favorable features worthy of consideration should Congress decide to entertain legislative solutions to the health insurance needs of laid-off workers. At the same time, we would call your attention to what the private sector is already doing and NAM's proposal in this regard.

CONCLUSION

Central to NAM's private sector approach is its administrative simplicity and use of already existing structures. A majority of companies, both large and small, provide a group health plan administered by the company or its agent. Use of this structure to assist the laid-off worker would require no new government agency or staff to operate the program. This approach could be implemented immediately to alleviate the short term need and could continue to offer extended benefits, family coverage and quick re-entry eligibility for the long term as well.

Appropriate health insurance coverage for the laid-off worker will assist the individual during a time of difficult transition.

This approach does not create a new federal entitlement or 50 separate state bureaucracies with accompanying administrative

overhead costs. It recognizes that programs for the poor and elderly have already been severely cut and that to offer federal assistance to yet another group, although their needs are great, would be inequitable.

Thank you for this opportunity to present our views on health insurance coverage for the unemployed. We look forward to working constructively with this Subcommittee and Congress on this and the other critical issues affecting our nation's economic recovery.

Senator QUAYLE. Thank you very much, Mr. Bliss.

Mr. Goldbeck.

Mr. GOLDBECK. Thank you, Senator Quayle.

Employers are not of one mind on this issue. Some are philosophically opposed to more governmental involvement; others view that such new benefits would be a work disincentive, and some cannot help but note the incongruity of reducing medicare and medicaid, at the same time, declaring new entitlement categories.

However, our group has come to the conclusion that this is a problem which is national in scope, not temporary in nature, and getting distinctly worse. Citing one example from our longer statement, a company in January of this year, had some 12,522 people on layoff. Of those 12,000, some 10,000 still had extended benefits through the company. But of the 10,378 that did have extended benefits, 10,155 lose them in the early part of 1983.

No one is to blame in this issue, and we have only victims to help. Employers must do their share. The top business priority is to gain the economic recovery, and this will not be served by driving millions of former workers and taxpayers deeper into poverty to gain eligibility for public programs. We would be a group without conscience if we did not feel willingness to join in a national system of public, private, and personal efforts. We can afford dollars here more than we can afford increasing numbers of uncared-for persons. Untreated illness only serves as a barrier in the path to returning to work, and there will be no method for treating this problem without adding some new dollars. The criterion for further involvement is State flexibility, with the Federal contribution tied to unemployment. This bill, whatever the final bill may be, should not be a surrogate for national health insurance. We cannot address all the Nation's health access issues or structural unemployment issues, which is certainly very different than layoff problems, through one piece of legislation rushed through at this time.

I say this not only because, as you might expect, our organization is not pronational health insurance per se, but also because to attempt to do so would simply result in the Congress ending up doing absolutely nothing.

There should be no disincentive for the current trends in privately-extended benefits. Making medicare a new minimum benefit package for extended plans would serve as such a disincentive, to be sure.

There should be no burden that causes decreased benefits for small employers, or increased unemployment, by having too extensive a period of extended benefits mandated, or mandating national pools. And I would urge, even in the case of the spousal extension—which we support, and recognize the propriety of—that there are certain employers for whom that could be, if it is implemented immediately, a devastating blow. One would only have to look into, for instance, the retail sector, where there would be, in several companies, tens of thousands of employees in that category. Nobody wins if the result of this effort is to force more people into a laid off circumstance.

We also do not believe that it would be beneficial to add a new category of dependents—unemployed parents.

We are willing to support, and believe it is terribly important, that the Government help the public hospitals that are receiving an undue portion of the dumptees in the system. As I said, the spousal extension is appropriate; the conversion plan is appropriate. We would concur that the 90-day extension benefit is a reasonable item. And we would urge that you look carefully at the concept of a minimum benefit package, such as some version of that espoused in the Waxman bill in the House, rather than thinking that the way to address a crisis is to address all problems with a mega-structure.

Lastly, we certainly support the emphasis on prevention in maternal and child health. There can be no greater investment in the future of this Nation. There are many ways that we have the opportunity, working with Congress, to extend benefits further. If the 90-day limit, were selected, one could grant employers tax credits for those companies that went beyond the 90 days.

I think we have to recognize that there is no dependency between this issue and the tax cap. We do not support the tax cap; we do support progress on this issue.

We do not believe that the bill should ever be written to include an increase in in-patient utilization incentives, as some would do by, for instance, making the drug benefit available only if you received it in the hospital setting. That seems to be totally contrary not only to the resources available in this legislation, but to the resources available in the Nation.

In conclusion, we must recognize that there is very little free care being given anywhere in the United States today. It is being given free to one because it is being charged extra to another. The employers in the United States today are going to pay for this issue anyway. We need to work with Government in a cooperative fashion, and do our share, so that we have a system to address the problems now for the future.

Thank you.

[The prepared statement of Mr. Goldbeck follows:]

**PREPARED STATEMENT OF WILLIS B. GOLDBECK ON HEALTH INSURANCE FOR THE
UNEMPLOYED**

My name is Willis B. Goldbeck, President, Washington Business Group on Health. We are here today because the problem you are seeking solutions to is real: there is a legitimate role for federal government involvement; and many of America's leading employers recognize that they, too, must contribute to the solution.

As you would expect, our membership normally seeks neither an expansion of government nor mandated increases in the benefits provided to employees and their families. However, we do acknowledge that unemployment, with the resulting loss of medical insurance benefits, is a problem of national dimensions. As such, the responsibility must be apportioned among the various sectors of our society: Government must do its share to reduce any significant health crisis; the individuals involved will have to make painful personal resource allocation decisions thus sharing in the financing of any proposed remedy; charity on the part of medical care providers and special compensating community action programs are both necessary and, happily, becoming more prevalent. Finally, management and labor must do their share, not only as tax payers but also by the direct provision of benefits extended for a reasonable period to those who lose their jobs through no fault of their own.

We reached these conclusions based upon an analysis that determined:

1. No single sector of society can afford to assume responsibility for a total solution, thus a joint effort will be essential.
2. This is a problem which has no one to blame, only victims to help.
3. Society in general and the economic recovery in particular will not be served by either ignoring the problem or by driving millions of former workers—and tax payers—into poverty to attain eligibility for existing public programs.
4. The problem is not a reflection of temporary economic doldrums but rather of the changing nature of work in America. Therefore, unlike past occasions when the issue has arisen, this time a national response is appropriate.

Attached as an appendix is a brief review of Trends In Extended Benefits which was initially presented in our January 24 testimony to the House Energy and Commerce Committee.

Senators Dole and Riegle and Representatives Waxman and Walgren and their co-sponsors all deserve credit for forcing this issue onto the public agenda and offering important proposals.

In reviewing these proposals, we tried first to clarify the goal, establish some basic principles and then assess which elements of the proposals would be most successful in meeting these criteria.

Goal: To assist those who have lost, or in the future may lose, medical insurance as a result of unemployment.

- Principles:**
1. To establish a system of joint public, private, and personal efforts to address the current problem and similar instances that may arise in the future.
 2. This unique program should not be a surrogate for national health insurance nor should it attempt to address all the other problems in health care financing and delivery.
 3. States should be given maximum flexibility in program design and financing.
 4. Federal financing should be seen as a catalyst for state and private sector program development.
 5. There should be no pretence that this special program can provide replacement insurance protection. A new minimum benefit package should be offered.
 6. That benefit package should have some emphasis upon prevention.
 7. Requirements on employers should:
 - A. not be a disincentive for the growing number of voluntary and negotiated extended benefits.
 - B. not impose such a burden that the provisions of basic medical insurance will be reduced (small employers) or that unemployment will be increased (large employers already in major economic difficulties.)
 - C. recognize that many families now have two wage earners both of whom have access to private insurance benefits.
 - D. not result in financing pools and programs in which the

unemployed receive greater benefits than they had while working (which would be the case if Medicare or many Medicaid programs became the "minimum" benefit.)

8. Financial assistance should be targetted to those hospitals which are providing an increasing amount of uncompensated care due to the unwillingness of other hospitals to accept those who have lost insurance due to unemployment.

Our members are currently responding to a survey that sought their views of each legislative proposal. All the results are not in but a review of the completed responses shows:

1. Agreement to provide an immediate access period to a spouse who has lost their own job.
2. Agreement that all employment-based medical insurance should include a conversion opportunity.
3. Acceptance of the 90 day benefits extension requirement as representative of a moderate approach which, while far from inexpensive for employers, is consistent with the trends in benefit extension.
4. Opposition to nationally mandated pools. If these were experience rated, like unemployment compensation, then the companies with the worst economic conditions would have to pay for the whole pool. Alternatively, if the pool is not experience rated, then those firms which never have lay-offs would be paying millions for a benefit that their workforce never receives.
5. Support for the minimum benefit approach in the Waxman bill. The importance of this proposal should not be overlooked. It is a bold statement which recognizes that the federal government has an appropriate role in crisis reduction but, that role does not necessarily extend to maintenance of the status quo or to providing a guarantee of cost-free care for every real or perceived need.
6. Concerns that Congress not provide an unnecessary incentive for inpatient utilization (such as denying coverage of drugs for chronic care patients unless they are hospitalized.)
7. Support for the prevention orientation of the maternal and child care proposal coverages.

8. Support for state program flexibility and the provisions in the Waxman proposal that would allow employer requirements to vary by state within proscribed minimums.
9. Opposition to the concept of making employer plans responsible for unemployed parents of workers unless the parent is a dependent under the terms of the applicable IRS codes and existing employee benefits agreements.
10. We do not support proposals that create a dependency between the provision of health insurance for the unemployed and passage of a tax cap on employee health insurance benefits.

Conclusion

There can be no denying that the simultaneous loss of employment and health/medical insurance protection can be devastating. This is not an issue on which the employer community is likely to speak with one voice...which is quite appropriate since the impact of proposed legislation would vary dramatically depending upon a wide range of factors, many outside the control of individual employers.

Some companies simply do not accept the philosophy that government (and mandated private sector programs) should intervene in the economic ups and downs that represent a fluid, primarily free market, economy. Concerns are raised that special benefits become just one more disincentive to accept new employment opportunities, especially those with weak benefits. Others note the seeming incongruity of rushing to create special legislation to help those who have just lost their jobs when programs for those who are already destitute are being reduced.

All employers realize that the price of any new plan will be high. Utilization is high for those who are unemployed thus resulting in not only expenditures for actual claims but also in upward pressure on the premiums for experience rated firms.

Despite all these very real concerns, it is our belief that a carefully designed, modest program warrants support. There will be added costs for our members, but they also know that there is an unavoidable price of unemployment as costs for uncompensated care are shifted to private payers. The unemployed need help and we are prepared to do our share.

Appendix**TRENDS IN EXTENDED BENEFITS**

<u>YEARS OF SERVICE</u>	<u>EXTENSION OF BENEFITS</u>				
	<u>End of Month</u>	<u>End of Month Plus</u>	<u>6 Months</u>	<u>1 Year</u>	<u>2 Years</u>
Less than 1 year	X	X	X		
Less than 2 years	X	X	X		
2-10 years			X	X	X
More than 10 years			X	X	X

This chart captures the primary categories of extended benefits in relation to duration of service. Many companies have no benefit extension; others have a set amount regardless of service and there are countless variations that defy placement on any chart that would remain comprehensible.

UTILIZATION

Not surprisingly, our companies report increased utilization of medical benefits during periods of layoff. And this does not count the increase in diseases and accidents that are directly attributed to unemployment itself. Elective surgery is a major area of increase.

INSURANCE

Nationwide is marketing a hospital/surgical benefit in 60 or 120 day policies specifically aimed at the recently unemployed. While not inexpensive, they are considerably less than a regular, non-group policy which, with a \$250 deductible, would be approximately \$1900 per year. For a typical 30 year old couple, the unemployed plans would cost (60-day) \$56.60 (120 days) \$113.00. Coverage is limited but would be a major asset in any medical crisis.

EMPLOYEE CONTRIBUTION

Many companies require laid-off workers to make some financial contribution to the insurance premium. There is a great variation in this practice with duration of service, duration of layoff, and number of dependents among the determining factors.

COVERAGE COMPARABILITY

Some employers reduce the coverage for those on extended benefits. Again, the patterns are not conclusive. While some emphasize protection from catastrophic expenditures, others drop the major medical although continuing the basic hospital and surgical benefits. The trend is to keep the full coverage and drop dental.

"LOST" BENEFIT

The total number of persons laid off in recent years contain many who had been employed for so short a time they had never passed through the waiting period. Thus, they had no benefit to lose. Another category had benefits but not enough seniority to earn any benefit extension. Then there are all those who had benefits and varying degrees of extensions. All of which further shows the dangers of thinking of the unemployed as a single group with comparable circumstances.

SELF-PAY OPTIONS

Several companies reported that they offer those laid off the opportunity to buy into the full group plan coverage. Acceptance runs from 12-33% of those eligible thus many must conclude that the price is too high, either in absolute terms or in relation to other demands on their shrinking resources.

NOTE — This information reflects the experience of a select group of very large firms. It is not typical of all businesses.

Some typical examples are:

<u>COMPANY</u>	<u>SERVICE</u>	<u>BENEFIT EXTENSION</u>
Tenneco Salaried	less 6 month 6-12 months 1 year	1 month 6 months 1 year
Hourly	less than 4 years more than 5 years	6 months 1 year
Libbey-Owens-Ford Glass division		6 months
Motorola		1 year
Alcoa	less than 2 years 2-20 years more than 20 years	26 weeks 2 years full retirement level
Kodak		end of month plus 2 months
American Can	less than 10 years more than 10 years	6 months 23 months
Kroger		end of month plus 2 months
Bethlehem Steel	2-10 years more than 10 years	6 months 1 year
Boeing		60-90 days
Ford	less than 10 years more than 10 years	1 year 2 years
Goodyear Salaried	Less than 1 year 1-2 years more than 2 years	3 months 6 months 2 years
Hourly	less than 2 years more than 2 years	3 months 2 years
Westinghouse	3 years	1 year
Armco	less than 2 years 2-10 years more than 10 years	1 month 6 months 1 year
Kimberly-Clark		1 year

CHANGING NATURE OF WORK IN AMERICA

On the surface, it sounds so reasonable and so simple: provide emergency legislation to give health insurance coverage to those who lose coverage due to loss of employment.

Below the surface lies a morass of rapidly changing demographics, emerging shifts in how we value work, trends in technology and education which are out of balance with the needs and skills of our workforce, and the harsh reality that there are good reasons for what we have come to call structural unemployment.

Like it or not, the nation is not facing a short term unemployment problem that is suited to emergency approaches. To further complicate matters, the overall matrix of economic problems, including the deficit, are forcing reduced funding to public health, Medicare and Medicaid. Thus the ethical dilemma: do we create a new category of persons eligible for assistance at the very time we are cutting back for those already in dire need.

HOW WE ARE CHANGING: WHO WE ARE

The American worker is increasingly female or foreign, or both, and is getting old. While our total fertility rate has stayed below replacement level since 1976, immigration and longevity have been the keys to population growth. For every 4 persons who entered the labor force in the 1970s, only 3 will do so in the 1980s. One result of an aging workforce is a reduced pool of those able or willing to take low skill, night shift, or hazardous jobs. Another complication is the incompatibility of a youth-oriented education system when it is the adult worker who needs education and training to be of value in tomorrow's job markets.

Between 1969-79 we consumed, but surely did not assimilate, 4.3 million immigrants. Our "melting pot" was swamped by a 815% increase in Asian immigration while the inflow from Europe decreased by 46%. Mexican immigration alone went up 92.8%. It is not just the nature of work but also the worker who is changing.

In the process of these and other changes, the family unit of a working father and a mother as homemaker has been transformed from a classic to a myth. Work in previous generations was unavoidable if one was to survive and the structure of work fit the family structure. Today, we see both structures in the midst of change.

HOW WE ARE CHANGING: THE VALUE OF WORK

We were trained to consume, to live for the next generation, to work in order to eat, to produce in order to win. Although from different political isms, Karl Marx and Adam Smith were allies in fostering work ethics that are increasingly meaningless for post-industrial societies. As a nation, there is no longer a necessary relationship between productive capacity and full

employment. We may need full employment for many other reasons, but not to produce the goods and services for either survival or growth.

The structure of work is changing to meet this new reality. Job-splitting, flexitime, permanent part-timers, compressed work weeks, and cafeteria plans are all related to the new prevalence of dual-earner families, few children, and strikingly different values being attached to work itself.

The shift from a manufacturing society to a post-industrial information society has been accompanied by other shifts:

- from replacement demand to maintenance demand
- from an emphasis on quantity to one on quality
- from fear-based incentives to self-realization and participatory management
- from the consumption ethic to one of ecological conservation

We have chronic un, and under, employment in part because we have so over-inflated the criteria for jobs that many who are indeed capable are not eligible. From all of this, we have a growing number of those whom Willis Harmon has called "the superfluous people", those not fortunate enough to be employed while existing in a society where the fact of employment is still deemed a prime indicator of successful participation and contribution to that society.

HOW WE ARE CHANGING: NEW VALUES, NEW BEHAVIOR

Waiting for our traditional industries to "recover" is no less a fantasy than waiting for ET to phone home. We're already in Naisbitt's "information society", Lumford's "bio-technic culture", and Robert Hutchins' "learning society". All these and many more are delivering the same message.

Public behavior is already reflecting these changes. Leisure time has never been more highly valued. Appropriate technology with its emphasis on decentralized production and doing more with less is in sync with America's new migration to unincorporated rural areas. The high tech of telecommunications is helping the entrepreneurial spirit converge with the "small is beautiful" value orientation.

Let me give an example to demonstrate the impact of the changing nature of work as contrasted with the traditional view of layoffs.

The following chart describes the workforce of a southeastern manufacturer which offers hourly workers with 3-10 years of service a one year extension; two years if beyond ten years of service.

HOURLY WORKERS

<u>Year</u>	<u>Total</u>	<u>On Layoff</u>
1980 (January)	22,122	642
1981	20,466	1,598
1982	16,165	4,682
1983	14,353	3,662

From this chart you can see a reduction of 7,769 yet only 3,662 now on layoff. The difference (4,107) represents those already "structurally" unemployed and thus beyond the responsibility of their former employer.

Another example shows the growing severity of the problem. A midwest heavy equipment firm currently has 12,522 on layoff. They average 226 days on layoff. Of the total 10,378 still have employer provided extended health insurance coverage. However, 10,155 will lose that in 1983.

Whether from the management or union perspective, one must ask if it would be good policy for the government to require firms, some of which have reasonable health care coverage, to expend even more funds for extended benefits. New financial obligations can only result in more layoffs or reduced compensation for those who remain employed.

NOTE: — Data compiled January 23, 1983.

Senator QUAYLE. Thank you very much.

Mr. Ozga.

Mr. OZGA. Thank you. My name is Jan Ozga, director of health care for the U.S. Chamber. On my left is Michael Romig, manager of the chamber's employee benefits policy.

The chamber is deeply concerned about unemployed persons without health insurance, and we are equally concerned about the proposal to provide health insurance to these persons, and the cost of such programs to employers, employees, and taxpayers. We believe voluntary action, aided by appropriate consumer information, is an effective response to this problem.

We are opposed to establishing more entitlement programs and financing them with nonexistent Federal funds or through a new tax on health insurance premiums. We think the problem, whatever the magnitude may be, is best resolved at the State and local level.

Many employers provide very extensive health insurance coverage to their employees on layoff. For example, the auto industry offers as much as 2 years of continuous coverage after employees are severed. For most employers, continued coverage ranges from one to three months, which effectively provides complete protection for about two-thirds of the unemployed.

Nearly every State insurance code requires employers to offer continued enrollment at employee expense to all employees who leave the job.

Many of the unemployed come from households in which other members have some form of health insurance—for example, one-half of unemployed married men have a working wife, and three-quarters of unemployed married women have a working husband. Overall two-thirds of those families with some unemployed have someone else in the family who is working.

The unemployed may purchase private health insurance policies, the cost of which may vary depending upon the type of coverage. In addition, medical expense coverage for accidents is available, as in insurance policies covering auto and homeowner coverage, and for those ages 65 and over, medicare is a readily available source of protection.

Finally, for those unemployed who have no health insurance, there is help from other family members, as we have heard today, friends, or charitable organizations, and from the many physicians and hospitals who have responded with reduced-cost or low-cost health care—free care, I should say. And in some cases, there is the social safety net of medicaid and again, as we have heard today, State and local health department services.

No one has adequately defined the problem of the unemployed and health insurance, and without such numbers, we are left with very expensive solutions to a problem that may require a much less costly remedy.

The Congressional Budget Office estimates that there are 11.4 million persons who are unemployed, 5.3 million of whom have lost their employer-provided health insurance. What we do not know is how many of those people can turn to the options we just described.

Faced with this dilemma, Congress is considering new entitlement programs such as S. 811, Federal mandates and employer group health plans, such as S. 307, or a combination of these, such as embodied in S. 951. Their annual cost could reach as high as \$18 billion. The potential for an expensive program exists because of certain political situations. For example, who would be served—unemployed families or households? Must they be without health insurance, and for how long? What if they are unemployed, but did not have health insurance? Will there be a means test?

The second difficult choice would be over how much health insurance would be provided. If it is too generous, will people drop their present coverage to obtain it? If it is catastrophic only, what level is fair to both taxpayers and those who are covered?

Employers would have to expand their group health insurance plans under certain proposals, which we estimate would add \$2 to \$6 billion to annual health care costs. If S. 307, with its 1 year of required continued coverage is enacted, how will financially troubled firms survive? After all these firms were forced into layoffs because they could no longer afford to employ some of their workers. How are they going to pay for health insurance—by laying off more workers?

Finally, there are the small firms who have been able to provide minimum health benefits for their employees. Are they going to drop that coverage or reduce it further?

We are also concerned by the prospect of one more federally mandated labor cost, which again, we have estimated has undermined our Nation's productivity and our international competitive position. Much of this is traceable to Federal mandates. If we are to restore our productivity and restore our international competitiveness, and we want to increase employment, and we must be mindful of these costs.

Thus, the U.S. Chamber recommends against enactment of a special program to provide health insurance benefits to unemployed workers. The present arrangements, consisting of a combination of employer-provided coverages, individually purchased coverages, State-level statutes, municipal health services, medicaid and medicare, free medical services where they are urgently needed, are largely meeting the need.

Finally, economic recovery has started, and its benefits are imminent. A higher level of employment that lies ahead is the best solution to the health insurance coverage problems of those currently unemployed. These options are clearly preferable to Federal intervention that could evolve into open-ended entitlement programs, increased Federal deficits, impeded economic recovery, and the addition of unmanageable burdens on small business.

One final note, Mr. Chairman. As was expressed by a previous witness, Mr. Goldbeck, we, too, are adamantly opposed to financing such a program through a tax cap, which has a number of problems associated with it, which we outlined in our written statement that we submitted for the record.

Thank you.

[The prepared statement of Mr. Ozga follows:]

PREPARED STATEMENT OF JAN PETER OZGA ON HEALTH INSURANCE AND THE
UNEMPLOYED

My name is Jan Peter Ozga. I am Director of Health Care for the Chamber of Commerce of the United States. Accompanying me today is Michael J. Romig, the Chamber's manager of employee benefits policy.

The U.S. Chamber is deeply concerned about the proposals to provide health insurance for the unemployed and the cost of such legislation to employers, employees and taxpayers. We believe voluntary action is an appropriate and effective response and stress our complete opposition to financing any such program through the enactment of a tax on health insurance premiums.

DEFINING THE PROBLEM

Most Americans obtain health insurance through their employment. Indeed, the most recent figures from the U.S. Department of Labor reveal that 75 percent of the workforce is covered by group health insurance (see Table 1 in Appendix). This coverage ranges by size of firm and union status (Table 2), by industry (Table 3), and by geographic area (Table 4). Another factor in coverage is length of service with an employer. Most firms require anywhere from one to six months probationary period before coverage becomes effective.

Although these data confirm that employment is an important element of health insurance coverage, they do not confirm, as some suggest, that unemployment translates into lack of health insurance per se. In fact, only a relatively small percentage of the unemployed ever face the prospect of high health care expenses without access to health insurance. Here's why we believe that the problem is relatively minor.

First, many employers provide very extensive health insurance coverage for their employees on layoff. Perhaps the best example of this is the auto manufacturing companies which offer as much as two years of continued protection. For most employers, the continued coverage ranges from one to three months, which effectively provides complete protection for about two-thirds of the unemployed (Table 5).

Second, nearly every state insurance code requires employers to offer continued enrollment, at employee expense, to all employees who leave the job. Some employers exercise this option.

Third, many of the unemployed come from households in which some other member is the source of group health insurance. For example, one-half of unemployed married men have a working wife and three-quarters of unemployed married women have a working husband. Overall, two-thirds of those families with someone unemployed have someone else in the family who is working.

Beyond this, and in the absence of any health insurance, the unemployed may purchase health insurance policies, the cost of which vary depending on how comprehensive the coverage is for hospital and physician's expenses. In addition, medical expense coverage for accidents is available in various other forms of individual insurance such as auto insurance and homeowners policies. And, for those aged 65 and over, Medicare is a readily available source of health insurance protection.

Finally, for those unemployed who have no health insurance, there may be help from other family members, friends or charitable organizations, and from the many physicians and hospitals who respond to urgent needs with reduced-cost or free services. And, in some cases there is the social safety net, i.e., Medicaid, which is available to the truly needy.

So far, no one has quantified the unemployed who actually need health insurance. Until these numbers are produced, it is difficult to fashion an appropriate response. Without such numbers, we are left with very expensive solutions to a problem that may require a much less expansive solution. For example, there are 11.4 million people unemployed, 5.3 million of whom have lost their employer-provided health insurance. What we don't know is how many of these people can turn to the options described above.

COSTLY ENTITLEMENTS

Faced with this dilemma, Congress is being asked to consider fashioning new entitlement programs (S. 811), issuing federal mandates on employer group health plans (S. 307), or a combination of these approaches (S. 951). The annual cost could range as high as \$18 billion, according to testimony before the Senate Finance Committee by OMB Director David Stockman.

The potential for an exceedingly expensive program exists because of the inherently difficult political choices that such a program presents for those who would design it. For example, who would be served? Unemployed families or households? Must they be without health insurance and for how long? What if they are employed but do not have health insurance? Is there to be a means test?

A second difficult choice would be over how much health insurance to be provided. If it is too generous, will people drop present coverage to obtain it? If it is catastrophic only, what level is fair to both taxpayers and those who would be covered?

Finally, there are the difficult questions raised by those proposals that would require employers to expand their group health benefit plans. Early estimates predict that this could add \$2 to \$6 billion to annual health care benefit costs. If S. 307 with its one year of required continued coverage is enacted, how are financially troubled firms to survive? After all, these firms were forced into layoffs because they could no longer afford to employ some of their workers. How are they to pay for health insurance? By laying off more workers?

Finally, there are the small firms who have been able to provide minimum health benefits for their employees. Are they going to drop that coverage or reduce it further?

We are also concerned by the prospect of one more federally mandated labor cost. The labor wedge in the United States, i.e., the cost of employing a worker over and above the wages that a worker and employer might agree upon, has undermined our nation's productivity and international competitive position. Much of this is traceable to federally mandated labor costs. If we are to restore our productivity and our international competitiveness and if we want to increase employment, we must be mindful of these costs.

TAX CAP FINANCING

OMB Director David Stockman has suggested using a tax cap to finance a program of health insurance for the jobless. We totally oppose this proposal. Our opposition to a tax on health insurance is premised on several considerations:

- o A tax cap simply will not generate the expected revenues since "excess" health benefits will be shifted to other forms of non-taxable compensation. We would then be left with one more unfunded entitlement program.
- o A tax cap would be a poorly disguised tax increase at a time when the need for economic recovery calls for less taxation.
- o A tax cap would be unfair to female, older, and handicapped workers and workers who live in high health cost areas. Developing a cap that varies by sex, age or geographic region might be more equitable, but it would be an administrative nightmare and would lead to more bureaucracy and regulation.
- o A tax cap would be difficult for employers who self-insure because they would have to calculate the equivalent of a premium. But once identified, this "premium" cost would be the target for state taxation, from which it is currently exempt.
- o A tax cap would increase health care cost by thwarting competition. Cost effective alternative delivery systems such as health maintenance organizations (HMO's) would be less attractive, because their premiums tend to be higher than those of traditional health insurance and thus subject to the tax.

In sum, taxing health insurance is an idea we vigorously urge you to abandon.

RECOMMENDATIONS

The U.S. Chamber recommends against enactment of a special program to provide health insurance benefits to unemployed workers. Present arrangements consisting of a combination of employer provided coverages individually purchased coverages, Medicaid/Medicare and free medical services are largely meeting the need.

Finally, we note that economic recovery has started and the benefits of such recovery are imminent. The higher level of employment that lies ahead in the next several years is the best solution to the health insurance coverage problems of those currently unemployed.

These options are clearly preferable to federal intervention that could evolve into open ended entitlement programs, increased federal deficits, impeded recovery and the addition of unmanageable burdens on small business.

SOURCE: Health Benefits: Loss due to Unemployment Committee on Finance, United States Senate, April 1983.

TABLE 1.—DISTRIBUTION OF FULL-TIME WAGE AND SALARY WORKERS BY GROUP HEALTH INSURANCE STATUS AND TYPE OF EMPLOYMENT

Type of employment	Percent distribution by coverage status			
	Total	Covered	Not covered	Do not know
Total	100	75	23	2
Private.....	100	73	25	2
Government:				
Federal	100	83	16	1
State.....	100	88	11	1
Local	100	81	18	1

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TABLE 2.—COVERAGE OF FULL-TIME WAGE AND SALARY WORKERS IN PRIVATE INDUSTRY, BY SIZE OF FIRM AND UNION STATUS

Size of firm and union status	Percent distribution by coverage status			
	Total	Covered	Not covered	Do not know
Total	100	73	25	2
Union contract.....	100	91	8	1
No union contract	100	67	31	2
Under 100 persons...	100	62	37	1
Union contract.....	100	87	12	1
No union contract	100	56	42	2
100 to 499 persons ...	100	87	12	1
Union contract.....	100	93	7	
No union contract	100	84	15	1
500 or more persons	100	94	5	1
Union contract.....	100	96	3	1
No union contract	100	93	7	

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TABLE 3.—COVERAGE OF FULL-TIME WAGE AND SALARY WORKERS IN PRIVATE INDUSTRY, BY INDUSTRY

Industry	Percent distribution by coverage status			
	Total	Covered	Not covered	Do not know
Agriculture.....	100	31	63	6
Mining.....	100	85	13	2
Construction.....	100	59	36	5
Manufacturing (durable).....	100	89	9	2
Manufacturing (nondurable).....	100	84	14	2
Transportation.....	100	81	17	2
Communication/public utilities.....	100	92	6	2
Trade—wholesale.....	100	78	19	3
Trade—retail.....	100	58	39	3
Finance, insurance and real estate.....	100	76	22	2
Services.....	100	61	37	2

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TABLE 4.—COVERAGE OF FULL-TIME WAGE AND SALARY WORKERS IN PRIVATE INDUSTRY, BY GEOGRAPHIC AREA

Geographic area	Percent distribution of coverage status			
	Total	Covered	Not covered	Do not know
New England.....	100	77	21	2
Middle Atlantic.....	100	77	20	3
East North Central.....	100	79	19	2
West North Central.....	100	70	28	2
South Atlantic.....	100	69	28	3
East South Central.....	100	70	28	2
West South Central.....	100	66	30	4
Mountain.....	100	67	30	3
Pacific.....	100	72	26	2

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TABLE 5.—DURATION OF LAYOFF BENEFIT PROTECTION FOR WORKERS WITH BENEFITS

Length of layoff benefit protection:	Percent
All workers with lay-off benefits.....	100
Less than 3 months.....	19
3 to 4 months.....	25
5 or more months.....	28
Varies by length of employment.....	22
Data not available.....	2

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Senator QUAYLE. Thank you very much.

I wonder if you would comment on the aspects of what Mr. Stockman outlined to the Finance Committee last week—the concept that the employer ought to allow the unemployed spouse to be picked up on health insurance coverage at the employee's expense; the concept of pay-as-you-go; the cap on the employer's health insurance deduction, and finally, if you are going to go with a block grant as a sort of last resort, the title XX aspect of funding. I would just be curious to hear your individual comments on those principles as outlined to the Senate Finance Committee.

Mr. Bliss, do you want to start off?

Mr. BLISS. Mr. Chairman, we think there are elements of the administration's proposal which are worthy of consideration. We agree with the spouse coverage, as we indicated in my statement, that a working spouse should pick up automatically the coverage of an unemployed spouse, and that would solve a good part of this problem.

We also agree with the administration's approach to the continuation of coverage after the employee is laid off. Indeed, we would go further by mandating, as tied to the Internal Revenue Code, a 90-day continuation of the existing coverage for that laid-off employee, and would add an additional year of coverage with a low-option alternative, which goes a little further than the administration.

Senator QUAYLE. Excuse me for interrupting you, but on those two points, what would be the additional cost to the employer? Has anybody looked at that?

Mr. ROMIG. \$2 to \$6 billion.

Senator QUAYLE. Do you agree with that figure?

Mr. BLISS. I do not necessarily agree with that figure. That is on the high side, I would say, the \$2 to \$6 billion.

Mr. ROMIG. This was an estimate provided by the Health Insurance Association of America in testimony before the Senate Finance Committee.

Senator QUAYLE. I suppose, if anybody wants to supply that information for the record—

Mr. BLISS. We would be glad to supply our own estimate.

Senator QUAYLE. I would just be curious myself what the cost to the employer would be.

OK, go ahead.

Mr. BLISS. We strongly disagree with the administration's proposal to tie a block grant to a cap on health insurance deductions. We think that is very misguided. It is somewhat incongruous for the administration to recommend taking away health benefits that have long been established for existing employees in order to generate revenues to pay for health insurance coverage for those who are unemployed. The two problems are not interrelated, and we think the administration is wrong in going down that track.

The justification the administration gives for the proposed cap, that it will increase revenues thereby making those revenues available for spending on the unemployed, is erroneous. We expect that if health benefits are reduced for existing employees, other tax-deductible benefits will be substituted in their place, and therefore,

there will not be any revenue generated for the Government by the tax cap ceiling. So we think the premise is erroneous.

And finally, it is sometimes suggested that the tax cap will have some benefit in controlling costs. Again, we think the premise is erroneous. The benefits that will be dropped for employees are the supplementary benefits, not the in-hospital patient care and the physician services, which are the machines which drive the inflationary, spiraling, costs of health care in this country. So we do not think that the tax cap will have the effect of controlling cost. We think it is a bad idea, and that it should be completely disassociated from the issues that are before the committee.

In general, we find some things to agree with in the administration's approach, and we agree, if necessary, a block grant would be the best form of Federal involvement. We frankly prefer the approach suggested by S. 811 to that proposed by the administration in providing for block grants.

Senator QUAYLE. Mr. Goldbeck?

Mr. GOLDBECK. Yes, I think it is beneficial that the administration has come forth with the formal recognition that this is a problem of national scope and warrants some Federal involvement, even though we may differ as to the source of the general revenues that would support that involvement.

On the issue of spousal access and the conversion, I have already commented. I think a block grant is a perfectly acceptable methodology of distributing funds. It works in some cases to be administratively cheaper, in other cases, not, and it is pretty hard to estimate in advance which it would be. Health insurance is certainly an issue which is ripe for local administration, and therefore, it seems as though it would be an appropriate one for which a block grant might work. I have no trouble with the idea of making title 20 available. I do not think it would be appropriate to rely on title 20, absent new moneys, however, because all you are doing then is asking the States to finance this health program by taking money away from other health programs. But making title 20 available is a perfectly reasonable thing to do.

You have heard that we oppose the tax cap. As to whether or not there is a definite amount that anybody has estimated for a particular number of days' extended benefits for employees, I certainly do not know of it. The cost for 90 days has not been separately analyzed. It would vary tremendously on what the category of employees were laid off—their age, their sex, and other actuarial factors.

The \$6 billion was the number that was originally thought of for the whole Nation under the Dole approach a couple of months ago. When that was first proffered, it was estimated to cost a half a billion dollars a month, so therefore, \$6 billion a year. But that would be a medicare or medicaid level of benefits for everybody who was uncovered, not 90 days of continuance of what they already had, which is really quite a different proposition.

Senator QUAYLE. Mr. Ozga?

Mr. ROMIG. Senator, I would like to reply to that, if I could.

Senator QUAYLE. State your name for the record, please.

Mr. ROMIG. Mike Romig. I am manager of the Employee Benefit Policy Center for the U.S. Chamber.

The administration's testimony the other day, clearly indicated that they did not think that the problem was as significant as unemployment per se. They suggested a much more limited program than any of the bills which now are pending before the Senate and the House of Representatives. Their program really consisted of just two parts—one, an employer requirement portion specifying that year-around open seasons be imposed on employer-provided health insurance. Of all of the options in the employee benefit arena that have been advanced, this would be the least expensive of the options. The most expensive, on the other hand, would be immediate entitlement to coverage on the first day of employment or shortly thereafter. Somewhere in between would be a continuation of coverage beyond the last day of employment. Those would be far more expensive, and that is where most of the money in the estimate of \$2 to \$6 billion could be found. Neither of those features are included in the administration's proposal.

The second part of their program deals with setting up an entitlement program of very short duration. They did not go to a medicare or medicaid addendum, because of the very dangerous precedents that it would set. They chose instead a limited block grant under title 20. What I find objectionable, and what we find objectionable, and all of the members of this panel find objectionable, to that proposal is the way it would be financed—specifically, their suggestion was to take their current tax cap proposal which would tax group health insurance whenever it exceeded certain levels and drop it by \$10 to \$20. In effect, it would take the 30-percent estimate of group health plans that would now be in excess of the cap and take it as low as, perhaps, 40 to 50 percent. I do not have the figures at this time for the numbers of people who would be effected. Therefore, what would probably result is all of the observations we made in our testimony, namely, that many of the plans would quickly move to make it cost-neutral to them. They would switch their compensation from group health to some other tax-free benefit as quickly as they could. In effect, we would have created an entitlement program without a source of funding for it. Then what we would have, of course, is a poorly disguised tax increase that, hopefully, at least from the employees' standpoint, would not ever reach them, but for some, it would. I agree with the other members of the panel here, that the tax cap seems to be a highly inappropriate way to finance this program. If the program is of such limited duration and does differ in the country, it seems to us that a more local approach is warranted.

As an attorney who is in active practice, I am oftentimes called upon to do pro bono work. The medical community can do so. We can work with the insurance commissions to set up statewide pools or focus just on a local, community-wide basis. It can be done. It is just that we are not focusing the resources on it. We are only called to put those resources together when this problem occurs, and it has been quite infrequent over time, and we never really find out where these problems are, because we do not have a mechanism to address them. And I think we can address it if we just focus, and figure out some way to bring that focus where it really is needed in the local community.

Senator QUAYLE. Thank you very much. I certainly thank the panel and look forward to working with you.

Mr. Seidman from the AFL-CIO.

Welcome, Mr. Seidman. Please proceed.

STATEMENT OF BERT SEIDMAN, DIRECTOR, DEPARTMENT OF SOCIAL SECURITY, AFL-CIO, ACCOMPANIED BY KAREN IGNAGNI, ASSISTANT DIRECTOR.

Mr. SEIDMAN. Thank you, Mr. Chairman.

I am Bert Seidman, director of the Department of Social Security of the AFL-CIO. With me is Karen Ignagni, an assistant director of that department, and our expert in the health care field.

I have a full statement which I would like to have included in the record, with your permission, and I can very briefly summarize it.

Senator QUAYLE. It certainly will be.

Mr. SEIDMAN. Mr. Chairman, the AFL-CIO commends you and the members of this subcommittee for holding hearings on one of the most serious and lasting consequences of unemployment, the lack of health care protection. We are pleased to have this opportunity to share with the committee our views on the immediate need for Federal legislation to provide jobless workers access to health services.

I would like to stress, Mr. Chairman, that we regard this as an immediate need. Indeed, it is yesterday's need, not today's need. It is a need which is going to continue for some time, as long as we have millions of unemployed workers in this country and their families without access to health care, and we would urge, as some other witnesses have done this morning, that consideration be given to the fastest possible way of providing health care for these people who are now deprived of it, without considering whatever desirable approaches there may be to dealing with this problem in the long term.

That can wait, but what cannot wait is providing health care for the people who do not have it. This is all the more true because all of the programs which have helped to sustain jobless workers have been greatly weakened.

Support systems which workers have relied on since the Great Depression are not longer able to cushion the blow of unemployment. As a result, joblessness is no longer a short, temporary setback for workers, as we have heard this morning. The longer periods of joblessness that so many workers suffer result in exhaustion of financial reserves and permanent health problems.

Despite years of effort the United States, unlike almost all other industrial countries, has no national health program to provide jobless workers and their families access to health services. Unemployment is worse in Canada, but there is no problem of health care for the unemployed, because they are assured health care coverage. In this country, access to health care services is contingent upon whether and where you work or how much you can pay.

Now, we in organized labor will evaluate legislative proposals to provide health care to the unemployed on the basis of the following principles.

One, the program must not concentrate exclusively on catastrophic care. You heard much more eloquently than I can say it, from the witnesses who have suffered because of their deprivation of care, why it is important to have more than catastrophic care. There is need, obviously, for preventive care, diagnostic services, and prenatal and post-partum care are especially important.

Second, the program must use cost-effective reimbursement mechanisms, such as negotiating per capita agreements with providers.

Third, workers receiving, as well as those who have exhausted unemployment compensation must be eligible for services.

Now, let me say, however, Mr. Chairman, that we are not suggesting that there be any duplication of existing coverage. If workers have coverage because it is continued on their jobs, that ought to be primary. If they have some other kind of coverage from a family member, that ought to be primary. But there are millions of workers who do not have any duplicate coverage, and it is for them, including those who have already exhausted their unemployment insurance benefits, they must be eligible for services.

Fourth, unemployed public employees, not just private employees, must be eligible for the benefits.

Fifth, if cost-sharing is imposed on unemployed beneficiaries, it should be limited to the nominal amounts required under medicaid.

Sixth, providers who participate in the program must accept assignment.

Seventh, a grant program should be created for public hospitals.

Eighth, funding for the programs must be based on real levels of unemployment and not the artificial level which is represented by the insured unemployment rate.

And ninth, the allocation formula for States should be based, as I have already indicated, on total unemployment rates.

The AFL-CIO supports S. 1154 introduced by Senator Kennedy and a distinguished group of cosponsors. We favor extending coverage to jobless workers who have exhausted unemployment compensation within the last 2 years and continuing coverage for 4 weeks after a worker has been rehired.

We support placing a cap on the amount of premiums and out-of-pocket payments that jobless workers would be required to pay under the plan. We believe the Federal matching formula in the bill is fair and would encourage most States to participate in the program; indeed, we would like to make sure that all States participate in the program.

We support the creation of a countercyclical grant program which would provide needed Federal financial support to essential community providers.

We also favor placing a cap on the amount of program funds that can be used to cover expenses associated with administering the program. We have serious reservations about giving States the option to set up insurance pools, and we think by and large that that is not the way to get this thing going quickly.

From the standpoint of efficiency and cost-effectiveness, therefore, the bill could be improved by requiring that medicaid function as the intermediary for the program.

Before concluding our statement, Mr. Chairman, I would like to give you our views on what has been discussed by previous witnesses, namely, the proposal to financing health care for the unemployed by placing a limit on the amount of tax-free employer contributions to health care

As other witnesses have said, and we agree, these are two totally different issues that should not be joined. We should not rob Peter to pay Paul. Congress must move quickly to provide access to health care for the unemployed. This proposal is controversial. It should not be mixed up with the issue of health care for the unemployed. We urge the Congress not to jeopardize passage of the health care program for the unemployed by holding it hostage to taxation of worker health care benefits.

So we urge you to act expeditiously as possible on a program to provide health care for jobless workers and their families, and we in the AFL-CIO stand ready to provide any assistance whatsoever toward immediate achievement that end.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Seidman follows:]

PREPARED STATEMENT OF BERT SEIDMAN, DIRECTOR, DEPARTMENT OF SOCIAL
SECURITY, AFL-CIO, ON HEALTH CARE FOR THE UNEMPLOYED

The AFL-CIO commends you, Mr. Chairman, for convening hearings to look into one of the most serious and lasting consequences of unemployment -- lack of health care protection. We are pleased to have this opportunity to share with the Committee our views on the immediate need for federal legislation to provide jobless workers access to health services; what we think this legislation should contain and our thoughts on the various proposals pending before the Senate. Our testimony will address S.1154, S.951, S.307 and S.811.

During the last two years, all programs which have helped to sustain jobless workers have been greatly weakened. The support systems, which workers have relied on since the great depression, are no longer able to cushion the blow of unemployment. As a result, joblessness is often no longer a short, temporary setback for workers, but is resulting in longer periods of joblessness, greater exhaustion of financial reserves and, frequently, permanent economic, social emotional and physical health problems.

Despite years of effort the United States has no national health program to provide jobless workers access to health services to enable them to cope with the continuing medical needs, the high cost of care and the high level of stress associated with unemployment. In every other industrial country except South Africa, health care is a right. All citizens are entitled to services. In this country, access to health care services is contingent upon where you work, or how much

you can pay. Only 22 states allow two parent families who do not exceed predetermined income levels to qualify for Medicaid.

The unemployed tend to postpone health care services until their conditions require emergency attention. When they do seek treatment, jobless workers use hospital emergency rooms and/or inner city hospitals. The unemployed have very few financial resources. Most cannot afford to pay for health care. Nonpublic hospitals that do not turn jobless workers away, ultimately add the cost to patients covered by private health insurance. As for public hospitals, these facilities continue to be the providers of last resort for the elderly, the poor and those without health insurance protection. Public hospitals are experiencing a tremendous growth in the number of uninsured patients they treat at a time when their financial support from local governments has reached an all time low. This new influx of patients could seriously jeopardize their ability to operate and continue to deliver services to the elderly and the economically disadvantaged who have always depended on them.

The AFL-CIO knows that the Chairman and the other members of this Subcommittee are concerned about the health care needs of the unemployed. We hope that in a very short time legislation will be enacted. For the first time since World War II, and as a direct result of so many people going without health care services, infant mortality is again on the rise in our country.

Before sharing with you our views on all of the proposals which have been introduced in the Senate, the AFL-CIO would like to state clearly our answer to those who assert that legislative solutions are unnecessary and that voluntary programs can adequately meet the health care needs of jobless workers. Although we acknowledge the importance of voluntary programs and have been working with the

American Medical Association, the American Society of Internal Medicine and other specialty societies, the AFL-CIO does not regard these efforts as adequate substitutes for a nationwide program to provide health care for the unemployed. As a society, much more needs to be done -- and done immediately, unless we are prepared to stand by and watch jobless workers suffer with neglected health care problems.

Organized labor will evaluate all legislative proposals to provide health care to the unemployed on the basis of the following nine principles:

1. The program must not concentrate exclusively on catastrophic care. If the program is to be cost-effective and meet the health care needs of the unemployed, preventive care and diagnostic services must be offered. Prenatal and postpartum care are especially important.
2. The program must use cost-effective reimbursement mechanisms, such as negotiating per capita agreements with providers.
3. Workers receiving as well as those who have exhausted unemployment compensation must be eligible for services.
4. Public employees must be eligible for the benefits for which other employees are eligible.
5. If cost-sharing is imposed on unemployed beneficiaries, it should be limited to nominal amounts required under Medicaid.

6. Providers who participate in the program must accept assignment.
7. A grant program should be created for public hospitals.
8. Funding for the programs must be adequately based on levels of unemployment.
9. The allocation formula for states should be based on total unemployment rates.

The AFL-CIO supports S.1154 introduced by Senators Kennedy, Riegle, Metzenbaum, Eagleton, Randolph, Pell, Matsunaga and Dodd. We favor extending coverage to jobless workers who have exhausted unemployment compensation within the last two years and continuing coverage for four weeks after a worker has been rehired. We support placing a cap on the amount of premiums and out-of-pocket payments that jobless workers would be required to pay under the plan. We believe the federal matching formula in the bill is fair and would encourage most states to participate in the program.

We support the creation of a countercyclical grant program which would provide needed federal financial support to essential community providers. We also favor placing a cap on the amount of program funds that can be used to cover expenses associated with administering the program. We have reservations about giving states the option to set up insurance pools. Unless private insurers were to negotiate risk contracts with states, they would have no incentive to be anything more than bill paying intermediaries. From the standpoint of efficiency and cost-effectiveness, therefore, the bill could be improved by requiring that Medicaid function as the intermediary for the program. Currently one-third of the allocation

formula in the bill is based on insured unemployment rates. Insured unemployment rates do not even accurately reflect the numbers of jobless workers currently receiving compensation since they do not include workers receiving extended benefits or federal supplemental compensation nor do they reflect those who have exhausted coverage. Therefore, to make absolutely certain that states with the greatest need receive funds and, especially if eligibility is expanded to include more workers who have exhausted benefits, we recommended allocating all funds under this bill to states on the basis of their total unemployment rates.

S. 951 introduced by Chairman Dole along with Senators Durenberger, Heinz and Spector, attempts to share scarce resources equitably among the unemployed, states and the federal government. Although we support this basic approach to the problem, we have reservations about eligibility, cost-sharing, the state match and the authorization level. We fully support the view that health care for the unemployed be administered through state Medicaid programs. This puts the states at risk and provides strong incentives for them to negotiate cost-effective reimbursement contracts directly with providers.

In testifying before the Senate Finance Committee, the AFL-CIO urged that the authorization in S. 951 be increased to a level that adequately addresses the health care needs of unemployed workers.

S. 811 introduced by Senators Spector and Heinz, is a good first step towards providing financial incentives to states to become case managers and negotiate cost-effective reimbursement contracts directly with providers. If the Committee considers this proposal, we recommend

tightening it up considerably to provide more guidance to states. Specifically, the bill should contain a minimum benefit package, which states can improve upon, but can offer no less. There should be limitations on premiums and out-of-pocket payments by unemployed workers for services, and Medicaid should be the intermediary in all states.

The AFL-CIO recommends that if the Chairman introduces legislation to provide health care to the unemployed, he consider using an allocation formula like the one in S. 811. The formula in the Spector-Heinz bill allocates one-third of the amount to states on the basis of the relative number of unemployed who reside in each state; one-third on the basis of the relative number of unemployed individuals in excess of 6 percent of the civilian labor force in each state; and one-third on the basis of the relative number of individuals who have been unemployed for 15 weeks or more and who reside in each state. This would assure that states with the highest unemployment rates and, therefore, the greatest need would receive their fair share of federal funds to provide health care for the unemployed.

The AFL-CIO would like to commend Senators Riegle, Levin and Metzenbaum for acting swiftly on this problem by introducing S. 307 early in this Congress. We do have reservations, however, about administering a national program of health care for the unemployed through state insurance pools. We also are concerned about the high deductibles that could be imposed on jobless workers and the lack of coverage for primary care.

We would like more time to study the effect in S. 307 of requiring employers to continue health insurance coverage for laid off workers.

S. 307 would require unemployed workers to pay a premium of 20 percent and deductible of \$500. The AFL-CIO believes that the federal government should set a cap on premiums and the states should have public hearings to decide whether premiums are to be imposed and, if so, how much. In addition, if jobless workers are required to make out-of-pocket payments for services, they should be limited to the nominal amounts now authorized under Medicaid.

Finally, since state and local governments can decide on their own whether to contribute to state insurance pools, it is not at all clear in S. 307 how their employees would receive health care services if they were laid off.

Before concluding our statement, Mr. Chairman, I would like to give you our views on the Administration's proposal to finance health care for the unemployed by placing a limit on the amount of tax free employer contributions to health care. These are two totally different issues that should not be joined. Nor can we try to rob Peter to pay Paul. Congress must move quickly to provide access to health care for the unemployed. There is widespread support for such a program. On the other hand, there is widespread opposition to placing an arbitrary limit on tax free employer contributions for health insurance. We strongly urge that Congress not seek to prevent passage of a health care program for the unemployed by holding it hostage to extracting a pound of tax from health care employer payments.

Today, the ravages of recession have cut deeply into the lives of millions who have never been jobless, who have never been without health care protection. The ideal solution to this problem is a revived economy with jobs and the benefit protection that usually accompanies that job. In the meantime, we must minister to the victims, the wounded of our national economy's breakdown. As a major step to that end, we urge you to act expeditiously on a program to provide health care for jobless workers and their families.

Senator QUAYLE. Thank you, Mr. Seidman. I appreciate your testimony, and I also appreciate the cooperation we have had from the AFL-CIO on this issue, and the Job Training Partnership Act, where you were very helpful in giving us some guidance.

I have just one question. In a hypothetical situation where you have both members of a family working, and one is laid off, and the other has the option to pick up the family coverage, do you believe that if that is the situation, that the unemployed person ought to be covered in any kind of a program that we would create, or do you think that since there would be the option with the spouse that is employed, that it should be incumbent upon them to opt for that family coverage?

Mr. SEIDMAN. Well, usually, the family is covered by the negotiated, in the case of a union, health care plan, or only the member is covered. It is very rare these days that only the member is covered in a negotiated plan, and therefore, we think that that situation is not likely to arise where the worker is simply given the option as to whether to be covered or not.

Senator QUAYLE. Let me try to rephrase it. Say you have two spouses working. Take a husband and a wife, and they both work, and the husband has full family coverage through his insurance at work. He is laid off, so they do not have that coverage. Now, the wife that is working, she could, in fact, opt to pick up the family coverage. That would be optional, and in most cases, they probably would. But if we had a program—what I am saying is—

Mr. SEIDMAN. Are you positing a situation in which she, somehow or other, would have to make additional payments?

Senator QUAYLE. Well, she would have to make additional payments, yes, because he would not be making any payments.

Mr. SEIDMAN. Under those circumstances, it would be extremely difficult for a family which has had two incomes coming in, deprived of what is in most families, by far the major income, to still be able to pay additional amounts for health insurance. So I would say that such people ought to be covered.

Senator QUAYLE. The amounts would probably be the same or similar. There would not be an additional amount. What you would be doing is shifting it from one to the other.

Mr. SEIDMAN. Well, if that could be done in such a way that it would not represent an additional financial burden on the family at a time when the family obviously could not afford it, then I

would say it should be done, but I do not know how that could be done.

Senator QUAYLE. In most cases, it would vary, but it would not be an additional financial burden. The family is losing one wage-earner, and it would probably not be cheaper for them to opt, if they had another program, into the coverage by the Government rather than opting into coverage under the other employer.

Mr. SEIDMAN. Are you talking about an employer-paid program? If it is an employer-paid program, the question is whether the employer would be willing to assume that additional amount for such workers and not for others; I doubt it.

Senator QUAYLE. Thank you very much.

Mr. Troy and Ms. Lehnhard.

STATEMENT OF JOHN F. TROY, VICE PRESIDENT, TRAVELER'S INSURANCE, HARTFORD, CONN., ON BEHALF OF HEALTH INSURANCE ASSOCIATION OF AMERICA, ACCOMPANIED BY J. MARTIN DICKLER; JAMES DORSCH; AND MARY NELL LEHNHARD, VICE PRESIDENT FOR GOVERNMENT RELATIONS, BLUE CROSS AND BLUE SHIELD, WASHINGTON, D.C.

Mr. TROY. Senator, good morning—or, good afternoon.

My name is John Troy. I am a vice president of Traveler's Insurance Co. I am accompanied by J. Martin Dickler, on my immediate right, and James Dorsch, of the Health Insurance Association of America. We have a lengthy statement, which we will file for the record, and I will try to be brief, because I think most of the points have been covered here this morning.

Most people in the United States obtain their health coverage through their employment. There are a variety of mechanisms for continuing coverage after termination of employment. They include group conversion provisions, temporary continuance under the group insurance policies, the regular insurance marketplace, and State pools for uninsurable individuals. Most insurers offer a conversion privilege in group policies to provide continued insurance protection when the employment-based coverage ends. The group conversion policy is issued without medical underwriting. This is an extremely valuable right, since the employee or his dependents may be in poor health. It should be noted that employer and union self-funded benefit plans are not subject to State regulation. However, most of these plans do include a conversion privilege and have made arrangements with their administering carriers to provide for a conversion.

In recent years, there has also been a trend toward increased use of the employer's group policy to extend coverage following termination of employment. Customarily, employer contributions for coverage extend for 1 or 2 months. Some unions have negotiated continuation of employer payments for up to as much as 24 months following layoff.

Many benefit plans provide for insurance to be continued under the group policy on payment of premiums by the individual. This is a very beneficial trend. At the end of the specified period, usually 1 year or less, the employee may then choose A group conversion policy. Upon leaving employment, an employee may elect to pur-

chase health insurance in the conventional insurance marketplace, where a broad range of policies may be available. However, the individual insurance marketplace may not be available to an employee due to his condition of health.

We would like to establish programs in every State, as we have done in Connecticut, Indiana, Minnesota, Wisconsin, Florida, and Delaware, to guarantee the availability of health insurance for all individuals at no cost to the Federal Government. I happen to be president of the Connecticut pool. However, ERISA is a major barrier to our seeking State laws setting up these programs. ERISA preempts State laws to the extent these laws require self-insured plans to participate in the State pools. Thus, self-insured plans are shielded from the economic burden of the pools, a burden which draws on the ever-decreasing insured base due to the growth of self-insurance.

These programs are particularly pertinent at this point, since all laid off employees are not indigent, and establishment of these State programs will not have an adverse impact on the Federal budget.

We note that S. 1154, introduced by Senator Kennedy, would require employers to include certain open enrollment provisions in their employee health benefit plans. That provision could be amended to also require employers who are self-insured to participate in Connecticut-type guaranteed availability plans. If the committee decides to act favorably on S. 1154, we strongly urge such an amendment, and we would be happy to work with the committee staff in the development of appropriate language.

I must distinguish at this point between State pools to guarantee the availability of insurance to uninsurable individuals and State pools such as in S. 307, which are for persons who cannot afford to buy insurance. The State pools in S. 307 are designed to provide health insurance to persons who cannot afford to buy private insurance. Mandated private health insurance pools is not an appropriate mechanism for those who cannot afford to pay.

Concerning the employee health tax issue, the administration has asked Congress to levy a tax on employee health plans. It is now proposed that the proposed health tax be increased to finance grants to the States for health insurance for the unemployed, while insisting that the purpose of the tax is to contain rising health care costs and not raise revenue. The health insurance industry opposes this proposal as discriminatory, unfair, and one that will be ineffective in controlling health cost inflation; nor, we suspect, will it raise the revenues suggested as labor-management negotiations rearrange the employee benefit plans.

Some of the arguments against the tax, we feel, are the following. It penalizes older workers in that elderly groups use health care more frequently than younger workers, and therefore, would have higher premium costs and have to pay higher taxes. It penalizes those in hazardous, high-risk occupations. Some groups of mining and industrial workers have bigger medical expenses than other groups such as white collar workers. Thus, these groups would either have to pay a higher tax or receive less benefits.

It is also a form of double taxation. We estimate that medicare and medicaid shortfalls resulted in \$7.9 billion being shifted to the

private sector in 1983 to make up for Government underpayments to hospitals. To shift these costs to the private sector and then put a tax on the resulting higher insurance premiums, we feel is unfair.

It also unfairly impacts certain geographical areas. Since health care costs are higher in large metropolitan areas, a single national tax cap does not take geographic differences into account, and this would particularly penalize those in high-cost areas, where most of the unemployment is, I would observe.

It could also result in reduced coverage for preventive care. If employees scramble to reduce their overall premium rates, essential preventive care services, such as out-of-hospital benefits, dental care, vision, mental health benefits, alcoholic and drug abuse programs may be dropped from benefit plans. Dropping these benefits is counterproductive to the goal of reducing overall health care costs.

We feel the most sensible approach to keeping hospital costs under control is prospective payment reform that applies to all patients, not just to medicare patients, as under the recent Federal legislation. It seems clear that an all-payor prospective reimbursement system can better deal with loss of health insurance than the current cost-based system. We are beginning to see some success with prospective payment all-payor systems in the four States they now exist.

Thank you.

[The prepared statement of Mr. Troy follows:]

PREPARED STATEMENT OF JOHN F. TROY OF THE HEALTH INSURANCE ASSOCIATION OF AMERICA, ON HEALTH INSURANCE COVERAGE FOR THE UNEMPLOYED

My name is John F. Troy, Vice President of the Travelers Insurance Company. I am accompanied by J. Martin Dickler, Actuary for the Health Insurance Company of America. The HIAA is a trade association of approximately 320 companies which together write over 85% of the country's commercial health insurance. We appear today on their behalf.

We are pleased to have this opportunity to explain the types and extent of health insurance coverage available to people who are laid off or otherwise terminated from employment and to make some comments on some of the ideas expressed to date.

Most people in the United States obtain their health care coverage through their employment as a so-called "fringe benefit." More than four-fifths of those insured in the private sector are covered in this fashion. Insurance companies offer a variety of options under which health care protection can be continued for the individual and his family. The major problem lies with who will finance the premiums and for how long.

There are a variety of mechanisms for continuing coverage. They include the group conversion provision, temporary continuance under the group insurance policy, the regular insurance marketplace, and state pools for high risk or uninsurable lives. Let me explain.

Conversion Privilege

The most common mechanism is the group conversion policy. It has been offered by group insurers for many years.

Many states require that a conversion privilege provision be included in group policies issued in their state. Most insurers offer a conversion privilege in all group policies, whether or not required by state law, to provide continued insurance protection when employment-based coverage ends. The terminated employee either needs protection temporarily until group coverage is available at new employment or a regular, longer-term individual policy because of other circumstances. In either case, the group conversion policy is issued without medical underwriting, providing that application is made within a prescribed period (usually 31 days).

This is an extremely valuable right, since the employee or his dependents may be in poor health. The insurance company is obliged to issue insurance regardless of their state of health, the only qualification being if there would be an overinsurance situation because of other coverage the employee has.

Historically, group conversion policies provided basic hospital and surgical benefits on a scheduled basis. In recent years, several states have passed legislation setting minimum standards for

benefit levels provided under group conversion policies. These have greatly increased the scheduled limits available under basic coverage. Also, about 13 states now require that a group conversion major medical policy also be made available, if the group coverage was major medical. These policies provide protection for both in- and out-of-hospital expenses, and feature high coverage limits. These policies are also issued on a non-medical basis if the employee makes timely application.

It should be noted that employer and union self-funded benefit plans are not subject to state regulation (per ERISA, Section 514) and, consequently, do not have to offer a conversion provision. However, many self-funded plans do include a conversion privilege and have made arrangements with their administering insurance company to provide it.

Continuance (Temporary) Under the Group Insurance Policy

In recent years there has also been a trend toward increased use of the employer's group policy to extend options available to terminated employees.

Customarily, employer contributions for coverage extend to the end of the month following the month in which active employment ceases. Some unions, notably Steelworkers and Autoworkers, have

negotiated continuation of employer payments for up to an additional twelve months following layoff.

Beyond this, many benefit plans provide for insurance to be continuable under the group policy on payment by the individual of the required premium. In recent years, there has been a trend towards increased use of the group policy to extend such options available to laid-off employees. At the end of this period, usually one year or less, the employee may then choose a group conversion policy. Thirteen states currently require some form of this extension under group policies.

The Conventional Insurance Market

Also, upon leaving employment, an employee may elect to purchase individual or family health insurance coverage in the conventional insurance marketplace of insurance carriers, Blue Cross/Blue Shield plans, and HMOs. A broad range of policies is available from insurance companies, subject to their underwriting requirements. Some companies offer short-term, temporary coverage (of 3-6 months duration).

Guaranteed Availability of Health Insurance

Six states provide persons who are uninsurable or in poor health an additional option. Connecticut, Rhode Island, Indiana,

Minnesota, North Dakota, and Wisconsin have created associations or state pools to issue individual insurance policies to such persons. A seventh state, Florida, is in process of formation. This type of arrangement can benefit not only terminated employees who do not elect a group conversion policy, but in fact any resident of the state employed or otherwise. This is an important development in removing barriers to health insurance protection.

We would like to set up programs in every state, as we have done in Connecticut, to guarantee the availability of health insurance to all individuals at no cost to the federal budget. However, ERISA is a major barrier to our seeking state laws setting up these programs. ERISA preempts state laws to the extent those laws require self-insured plans to participate in the state pools. Thus, self-insured plans are effectively shielded from the economic burden of the pools, a burden which falls on an ever-decreasing base caused by existing legal barriers to equitable competition. We feel strongly that all competitors in the employee health benefit market should share proportionately in any pool losses. The problem could be solved either by an amendment to ERISA or by legislation authorizing insurers to set up such pools and requiring all employee health benefit plan funding mechanisms to participate in such a pool as a condition of income tax deductibility.

These programs are particularly pertinent at this point since all laid-off employees are not indigent and establishment of these state programs would not have an adverse impact on the federal deficit.

We note that S. 1154 would require employers to include certain open enrollment provisions in their employee health plans. That provision could be amended to also require employers who self-insure to participate in Connecticut-type guaranteed availability plans. If the committee decides to act favorably on S. 1154, we strongly urge such an amendment and will be happy to work with committee staff in the development of appropriate language.

The Current Problem

The current mechanisms work reasonably well during good times, when people who leave one job are generally able to find another within a reasonable period of time. But, during periods of high unemployment, when unemployment may last for extended periods and millions of families may be involved, serious problems are posed in terms of who will pay the premiums.

The HIAA is one of six national organizations that participate in a coalition, under the leadership of Harvard Professor and former Labor Secretary John Dunlop, which is addressing the problems of

health care for unemployed persons. In addition to the HIAA, other organizations include the AFL-CIO, American Medical Association, American Hospital Association, Blue Cross and Blue Shield Associations, and the Business Roundtable. The coalition has suggested that the hospital and medical associations encourage their members to meet with business, labor, insurance, and other concerned groups to determine the extent of the problems in their local communities and to explore joint solutions.

It may be helpful to estimate the magnitude of the costs under discussion. As a rough first cut, we think we are talking about something on the order of two billion dollars per year to continue health insurance coverage for up to 12 months of layoff. This is based on 2.5 million employees on layoff as of December 1982 (Bureau of Labor Statistics), reduced by estimated adjustments (1) for two wage-earner families where the other spouse's employment continues and (2) for employees whose employers will continue to pay for their health insurance beyond the customary one and a fraction of months following layoff. If we based our calculations upon the 7.3 million employees who had lost their last jobs, which includes the 2.5 million on layoff, we believe the corresponding cost for a full year of coverage would be about \$6 billion.

Senate bills 307 and 951 represent approaches to providing health insurance benefits to the unemployed. There are important

differences between the two which will affect the costs of the two programs. Under S. 307, the cost of the program will depend on the extent that deductibles are used, as the proposal permits deductibles of up to \$500. Another important variable is the extent to which the 180 days continuation under the group policy requirement reduces eligibility for the program. Cost estimates are therefore very difficult; but on a rough basis, we would expect a cost of \$1 to \$3 billion for those who become eligible, if all were covered for a full year.

Under S. 951, there are savings stemming from the linkage of the benefits and provider payments to state Medicaid programs. For those eligible, who do not have other available group coverage through a working spouse, we would roughly estimate a cost of \$3 billion if all were covered for a full year.

We have some additional comments on S. 307 and S. 951 which we believe should be brought to your attention.

With respect to S. 307, we note that the pools would be required to offer three plans. Generally speaking, one plan would be preferable to avoid adverse selection. We also note that a self-insured state or local government employer could remain outside of the pool. Since state and local governments are today large employers, this may cause some to switch to self-insurance and adversely affect the financial operation of the pools.

Under S. 307, the intent seems clear to include self-insured employers in the state pools. We would note that this is an essential requirement. In Section 5, an exemption from participation in the pool is permitted for a group plan provider that provides certain extended coverage under the group policy. Section 5 presents problems, since it appears to provide opportunities for an employer to select against the pool, especially when there are no federal funds payable.

I must clearly and emphatically distinguish at this point between the industry's offer to set up and, if need be, to subsidize state pools to guarantee the availability of health insurance to individuals who are uninsurable for health reasons and state pools, such as in S. 307, which are for persons who can't afford to buy insurance because of a lack of money. The state pools in S. 307 are designed to provide health protection for persons who cannot afford to buy private insurance coverage. The private health insurance industry must here draw the line. It cannot afford to take even the first step, as a matter of law, to accept responsibility for those who cannot afford to pay. The responsibility for providing the necessities of life--i.e., food, clothing, shelter, and medical care--for those who cannot afford them is a community one, a dual responsibility through charity and tax-financed programs. It is not the role of the private insurance industry to accept responsibility for those who cannot pay; and we must strongly oppose any such proposal.

With respect to S. 951, the coverage of hospital and physicians' services should be defined to include diagnostic X-ray and laboratory services and radiation therapy, if essential services are to be included.

With respect to federal payments under the proposed program, we note that the maximum amount of federal funds that may be paid to any state is a function of unemployment levels, and not the level of medical care costs in the state. This could present financial problems for states that have substantially higher-than-average medical costs, even under Medicaid payment levels.

As a final comment on S. 951, an employer would have to add parents to the definition of dependents under his group plan in order to accommodate an employee's parent who lost his or her job. We believe this is an oversight, since it is extremely unusual for parents to be included in group insurance dependent definitions. We recommend that and legislation make clear that the existing dependent definition under an employer's group plan need not be changed.

Employee Health Tax

The Administration has asked Congress to levy a tax on employee health plans as part of its F.Y. 1984 legislative program. It has

now proposed, in testimony to the Senate Finance Committee on April 27, that the employee health tax, not yet enacted, be increased to finance grants to the states for health insurance for the unemployed, although insisting that the purpose of the tax is to contain rising health care costs, not raise revenue.

The health insurance industry opposes this proposal as discriminatory, unfair, and one that will do nothing to stop health-care-cost inflation, nor will it raise the revenue suggested as labor-management negotiations rearrange the employee benefit package.

Among the arguments against such a tax are a following:

- * It penalizes older workers. Elderly groups tend to use health care more frequently than younger, healthier workers. Hence, the cost of health insurance for a group which includes more than the average number of older workers not only will be higher but could discourage many employers from hiring the older worker. Under the Administration proposal, these groups will be adversely affected by a cap, while younger groups with similar coverage may not be taxed.
- * It penalizes those in hazardous, high-risk occupations. Some groups, such as iron workers or coal miners, are usually considered a higher "risk," and are typically charged higher

health insurance premiums. These groups could be unfairly taxed while other groups with similar coverage--such as clerical workers--would be unaffected.

- It is a form of "double taxation." The Health Insurance Association of America estimates that Medicare and Medicaid payment practices resulted in \$7.9 billion being shifted to patients covered by private health insurance in 1983 to make up for government underpayments to hospitals. For the government to shift these costs to the private sector and then put a tax on the resulting higher insurance premiums is patently unfair.
- It unfairly affects certain geographic areas. The cost of health care is higher in some areas, such as large metropolitan cities. A single national tax cap does not take geographic differences into account, and thus would particularly penalize those in high-cost areas. Conversely, it would allow the tax-free purchase of much more generous benefit plans by those in low-cost areas.
- It could result in reduced coverage for preventive care services. As employees scramble to reduce their overall premium rates, essential preventive care services such as dental care, vision care, mental health benefits, and alcohol and drug abuse services may be dropped from benefit plans. Dropping these

benefits does nothing to reduce hospital costs, and in the end may have the opposite effect.

The most sensible approach to keeping hospital costs under control is prospective payment reform that applies to all patients, not just Medicare patients. Rising costs are not just a Medicare-Medicaid problem but a national health care problem as well. A prospective all-patients system will force cost-saving incentives into the structure of hospital payments and operations and will have many times the impact of the band-aid approach of taxing workers' health insurance premiums.

We are beginning to see that prospective payment systems that include all-payers, including Medicare, now in place in four states, can work. There is no reason why the Congress should try the untested theory of taxing health insurance premiums--and every reason why it should not.

Again, HIAA and its member companies share this Committee's concern over the plight of the unemployed. We appreciate the opportunity to present this explanation. I will be pleased to respond to questions.

Background Facts
Group Conversion Policies

Most states require a conversion provision in group policies issued in their state. Most insurers include a conversion provision in all group policies, whether or not required by the state in which the group policy is issued. Self-insured employers usually have their carrier issue conversion policies even though no group policy is in force. Group conversion policies are issued non-medically, provided the employee applies within a prescribed period (usually 31 days) after termination. The employee may insure himself and eligible dependents. Most policies are guaranteed renewable, i.e., cannot be cancelled by the insurance company. An insurance company does not have to issue a conversion policy if the terminating employee happens to have other coverage and would be over-insured.

The types of coverage are as follows:

a. Basic Hospital and Surgical.

These policies cover hospital room and board up to a specific dollar limit for a specified number of days (usually 30, 70, or 120 days). Hospital special services are covered at actual charges up to a specified limit, (e.g., ten times the room and board

daily limit). Surgical charges are covered up to scheduled amounts. Several states have established minimum standards with respect to the room and board limits and surgical schedule maximums.

b. Major Medical.

About 13 states require that group conversion major medical policies be offered if the group policy provided major medical coverage. These policies cover both in- and out-of-hospital expenses typically included in major medical policies, except that some expenses such as room and board and surgical are subject to inside limits. In most states, a \$500 deductible applies, or base-plan benefits if higher. In seven states, a \$100 deductible is required.

Since group conversion policies are issued non-medically, they appeal to terminating employees whose health has deteriorated. As a result, claim experience under group conversion policies is higher than under standard underwritten policies with comparable benefits. As an offset, however, there is an expense savings since either reduced or no commissions are paid on conversion policies. Some companies require the employer to pay a group conversion charge when a terminating employee buys a conversion policy. This charge helps defray the cost to the insurer of providing the conversion privilege.

Senator QUAYLE. Thank you very much.

Ms. Lehnhard.

Ms. LEHNHARD. Mr. Chairman, I am Mary Nell Lehnhard, vice president of Blue Cross and Blue Shield Association. I will be happy to submit our statement for the record and summarize it very briefly.

Senator QUAYLE. Thank you.

Ms. LEHNHARD. I am afraid that, like many of the witnesses today, we note in our testimony that the scope of the problem and the effect on health status are unknown. We do cite in our testimony some anecdotal evidence that suggests that the health consequences could be serious, but we do not know the extent of the problem, and we will probably never know the full extent.

In terms of alternative financial or service delivery responses to the problem, we describe some new voluntary programs for the unemployed sponsored by Blue Cross and Blue Shield plans. We also cite some other related voluntary initiatives.

The bottom line here is that there are many voluntary efforts underway, and they should be encouraged. However, we do believe there remains a need for Federal action.

Regarding the cost of possible programs, we comment on three variable components, as follows.

First, enrollment. We know that given any set of eligibility criteria, the size and character of the enrollment will vary according to the cost-sharing imposed, particularly the premium charge. As out-of-pocket payments increase, there will be fewer and fewer enrollees, and a greater concentration of the high-risk employees.

Second, utilization. Our experience suggests that the employed have utilization rates of at least 130 percent above the average utilization of an employed group with basically comparable benefits. Again, the variables here are numerous and this is sort of a guess-timate.

Third, administration. Administrative costs will vary according to the complexity of program design and eligibility criteria. We suggest here only that the allowable administrative costs be explicitly limited.

As for the elements of a responsive and efficient national program, we suggest the following. Any Federal role should consist of stimulating State and private sector voluntary initiatives, and sharing in at least the short-run costs of these initiatives. A Federal program should be temporary, 2 or 3 years, until at least our base of experience and knowledge is sufficient to assess the need for a more permanent program. The States should be the focus of responsibility for designing a program best suited to their environment, and each particular State should have sufficient administrative flexibility to tailor its own program. The private sector should be urged to respond to the problem by requiring all employees, including the self-insured, to allow workers to change their coverage should they need to cover a laid-off spouse and provide for conversion to nongroup coverage without any waiting period of medical exclusion. Blue Cross and Blue Shield plans routinely provide for this type of conversion right.

We believe the minimum benefits should be designed to cover the most urgent medical care needs. Our experience suggests 9 to 15 in-

patient days and 5 to 10 out-patient visits, including emergency room care. We would also urge that prenatal, delivery, and post partum care be covered.

The extent of cost-sharing, we believe, should be decided by each State.

And finally, we also strongly advise against the administration proposal to fund the Federal programs out of a tax on employee health benefits. I think you have heard the arguments spelled out in detail today. And I would just add one other concern. Because health care costs tend to be higher, coincidentally, in those areas of the country where we have the heaviest industries, the tax burdens on those very parts of the country that have the most severe problems with unemployed workers would be proportionally larger, compared to the rest of the country.

That concludes my summary.

[The prepared statement of Ms. Lehnhard follows:]

PREPARED STATEMENT OF MARY NELL LEHNHARD, VICE PRESIDENT OF THE BLUE CROSS AND BLUE SHIELD ASSOCIATION, ON THE FINANCING OF HEALTH CARE BENEFITS FOR THE UNEMPLOYED

Mr. Chairman, I am Mary Nell Lehnhard, Vice President of the Blue Cross and Blue Shield Association, the national coordinating agency for 99 member Blue Cross and Blue Shield Plans. Today, Blue Cross and Blue Shield Plans serve more than 77 million members under private programs and an additional 26 million people under government programs. Many of our member Plans have had a variety of experiences with the difficult problem addressed by today's hearing: how to make health insurance affordable for people who have lost their jobs and thus lost their access to employment-based health benefit programs.

We would like to commend the Subcommittee for providing this opportunity to exchange ideas and information. On the basis of our experience, I will offer our comments on the questions you have raised, and will also outline the program elements we believe essential in any national program to provide health benefits to the unemployed.

The first question raised by the Subcommittee may be the most difficult to answer. That is, what impact has unemployment had on the ability of unemployed workers to secure adequate health insurance?

In January, the Congressional Budget Office estimated that as many as 10.7 million people, 5.3 million workers and their families, had lost coverage under their employer's health insurance plan. Unemployment has declined only .4 percent since these estimates were prepared. Thus, CBO's figures may still provide a reasonable account of the people who have lost their employer sponsored coverage.

Many workers who lose their coverage do have access to health insurance through a working spouse or by independent purchase of coverage. Director of the Office of Management and Budget, David Stockman, recently estimated that as many as 3.7 million

people could secure coverage through a working spouse and that 2.7 million unemployed workers would meet Medicaid eligibility criteria. Mr. Stockman's calculations leave only 2.1 million individuals in need of health insurance coverage.

Our experience tells us that the true number of uninsured individuals lies somewhere between these two estimates. We doubt the willingness of many workers to purposefully spend down to reach Medicaid income criteria; we also question the number of working spouses who have enough job tenure to qualify for employer based coverage. Today's unemployment has created a large pool of part-time workers and people who have many short terms of employment as they secure "odd" jobs. However, we do agree that many laid-off workers are able to and do convert their employer-based coverage to individual coverage. Others, without conversion rights, have sufficient financial resources to purchase individual or family coverage independently.

Unfortunately, however, today's unemployment is of such magnitude and duration, now averaging 19 weeks, that fewer and fewer unemployed workers can afford to buy coverage on their own. I would like to make it clear that Blue Cross and Blue Shield Plans make available options such as extension of group coverage, conversion from single to family coverage, continued coverage through group conversions and non-group coverage. All of our subscribers have insurance options available to them during a lay-off period. However, their real access to insurance is greatly impaired by the cost of coverage. The single barrier to maintaining coverage is ability to pay. The fundamental question, therefore, is not accessibility, but the means to pay.

Like the number of people who have lost coverage, the impact that this loss of coverage has had on health status is a debatable question. It can be argued that the upswing in stress related disorders are caused more by loss of job and income than by loss of

insurance. On the other hand, maintaining some insurance might greatly relieve the stress of income loss. Furthermore, it can be safely assumed that primary care and preventive services are the first to be delayed or foregone entirely, and they do have long-run health status consequences.

Again, we cannot quantify the national impact of either the loss of income or the loss of insurance. We have only occasional indications of localized impact, such as the recent report of increases in infant mortality in Michigan linked to a three-fold increase in the numbers of women who receive no prenatal care and to an increase in the number of women delivering babies by themselves or with the help of untrained personnel.

We do know that many local medical societies are voluntarily offering no cost or low cost care to the unemployed, and many hospitals are extending services whether or not payment can be made. We also know that many people are reluctant to accept such charity care. Whether such reticence is caused by pride or lack of information, it appears that many people are not seeking needed care. Thus, the true impact of unemployment on health status may not be known for several years, until the result of much unattended illness becomes known.

The Subcommittee has asked what impact loss of health insurance coverage has had on alternative methods for providing or financing health care. You probably are already familiar with one form of this impact, namely the shift of the locus of care from private to public institutions. For example, referrals of uninsured patients from private hospitals to Cook County Hospital in Chicago are reported to have increased 25 percent during the past 13 months. Detroit General Hospital reports a 30 percent increase in that period.

You may be less familiar with voluntary adjustments being made by some Blue Cross and Blue Shield Plans. Several Plans located in states with especially high unemployment rates have looked at new approaches to offering coverage to the unemployed. They have concluded that the unemployed need inpatient and outpatient coverage with low deductibles and copayments. Catastrophic type benefits, they reason, will not provide the financial protection needed. Indeed, the catastrophic coverage approach proved unpopular in the early 1970's when offered to unemployed workers.

To enable them to offer fairly comprehensive coverage at affordable premiums, these Plans have begun to develop voluntary cooperative relationships with providers and physicians in their areas. The Western Pennsylvania Blue Cross Plan, working with Pennsylvania Blue Shield, for example, has arranged a special program in which participating physicians and hospitals forgive cost sharing amounts. In addition, the Plan subsidizes premium payments. Through this cooperative undertaking, premiums for a limited family coverage are being offered to unemployed workers for about \$60 per month. We believe that experiences such as this, a rudimentary type of preferred provider arrangement, will have the additional benefit of helping us to establish more cost-effective delivery arrangement for the future.

In answer to the Subcommittee's question regarding the cost of alternative programs to insure the unemployed workers, I would like to break program cost into its three primary components: enrollment, service utilization and administrative cost, and discuss each in turn.

The difficulty of estimating, nationally, the potential size of the population needing insurance has been discussed. Whatever the size of that potential group, we know that it will be reduced in proportion to the amount of the premiums charged and other cost-

sharing features of the benefit package. As potential costs to the enrollee rise, there will be a natural inclination of only people most in need of medical care or those anticipating ill health to enroll in the program. Younger and healthier people will tend to go without coverage. We call this the problem of "adverse selection", which simply means that the per enrollee costs will be higher than they would be if a cross-section of all unemployed workers were enrolled. It also means, incidentally, that some proportion of the unemployed will remain unprotected, whatever program is offered — as long as it is voluntary and has a premium charge.

Utilization is also difficult to predict. In our experience, utilization of subscribers on extended coverage tends to be about 130 percent of average group utilization. As a result, Plans are closely examining benefit designs which offer adequate, but limited, coverage.

Administrative costs will depend greatly on the complexity of the program and the criteria of eligibility. The greater the restrictions and conditions on eligibility, the more difficult, and expensive, it is to implement and monitor. Yet, open eligibility may involve much higher total costs of services used.

These brief notes on enrollment, service utilization and administration indicate that the potential costs of a program to insure the unemployed are high and variable. We believe it is possible to establish a feasible program, however, by allowing local definition of eligibility criteria, establishing guidelines for limited benefit coverage and by keeping program administration as simple and straightforward as possible. In my remaining comments, I would like to outline the program elements we believe are necessary to establish a feasible program to insure the unemployed. Most of these elements already appear in one or more of the several Congressional bills related to this subject.

The Federal Role in Program Financing and Design

First, given the national scope of the problem, and its financial character, we believe a federal initiative to insure the unemployed is entirely appropriate. Second, while unemployment is a national problem, it appears to manifest itself differently in every state and even among communities within states. Therefore, we believe the federal initiative should serve to stimulate and assist development of locally defined programs.

We encourage you to consider a program which provides federal funding to states that demonstrate, by preparation of an acceptable plan, intent to meet basic program design requirements regarding administration, benefit coverage, eligibility, and private sector participation. We would suggest states be allowed to participate in whole or in part. That is, if a state has communities with severe unemployment problems, but not a high statewide unemployment rate, it should be able to participate on behalf of specific communities.

The Federal contribution should be based, in effect, on each participating State's costs of responding to the problem. One obvious approach is to calculate each State's relative share of the unemployment problem, preferably weighted by the extent of its long-run unemployment. That proportional calculation, applied to the Federal authorization of an appropriation would set the minimum Federal contribution. The maximum could be related to the State's estimated cost of a minimum benefit package made available under its plan. Allowing each State to make that calculation would take into account both the regional variation in hospital/medical costs, and the State's preferred approach to providing the benefits. The amount or percent of the State's contribution should be set in relation to the severity of its unemployment problem. How far any Federal appropriation could be stretched would of course depend on the number of States choosing to participate, and the required level of each participating State's contribution.

We would also suggest that states, as a condition of participation in the program, be required to mandate that all employers provide opportunities for group insured employees to extend their coverage to include laid-off spouses, and to convert to individual coverage when all other group insurance options are exhausted. Unfortunately, such state requirements would not cover the many large employers who are now self insured, due to the federal pre-emption (under ERISA) of state laws dealing with employee benefit plans. This problem also prevents States from requiring the self-insured employers to contribute to the State pooling arrangements mentioned above. We would urge resolution of this problem either by appropriate amendments in ERISA or by modifying the tax code to allow the same rules to be applied to all employers that deduct the costs of their employee health benefits.

Duration

We strongly suggest that the proposed program be one of limited duration, for example, three years. We do not believe that a long-term institutional response, such as a new entitlement program, is appropriate at this time. We do not know how long this severe unemployment problem will continue, and we are certain to gain some much needed experience with a variety of ways to cope with the problem. On the basis of such experience, a longer term program can be designed, if needed in the future.

Administration

We encourage state flexibility in administrative design. States should be able to administer the program themselves or to contract for administrative services. The different ways in which the States might finance the non-Federal share of the program will lead to different administrative designs. The example of the innovative program in Western Pennsylvania, cited above, may even lead Pennsylvania or other States to rely on the private sector for underwriting as well as administrative services, and that flexibility should be explicitly allowed.

We would also encourage placing a reasonable cost limit on administrative expenditures. The cap amount might be a percent of total program cost or a percent of the federal contribution.

Benefit Design

Blue Cross and Blue Shield Plans that have begun to consider programs to insure temporarily unemployed workers have determined that the benefit package must be limited to medically necessary inpatient and outpatient care. Generally, Plans suggest offering 9 - 15 inpatient days and 5 - 10 outpatient visits, including emergency room care. In addition, prenatal, delivery and postpartum care should be covered. States should be allowed to go beyond such minimal benefits to address the needs in their areas, although any State's medicaid benefit level should probably be the maximum level allowed.

States will want to consider applying cost sharing amounts to the benefit package. We suggest that they have the flexibility to make this choice. As indicated above, there are both advantages and disadvantages in enrollee cost sharing in a program like this. Cost sharing can discourage the unnecessary use of services, can constrain total costs

and can allow the public dollars to go further. On the other hand, cost sharing will promote "adverse selection", and the dollar value of even modest premiums, deductibles and copayments may be excessive for someone long out of work. Therefore, we believe that cost-sharing decisions should be made on a State-by-State basis, considering such factors as total funding available, the socio-demographic characterization of its unemployed population, the pattern of insurance coverage in its employed population and in its Medicaid program, and any other relevant factors.

Eligibility

Subscriber eligibility criteria also should be subject to local determination within the two broad conditions of (1) unemployed status and (2) no other source of insurance coverage — private or public. Beyond this, states should be able to define eligibility as broadly or narrowly as they consider necessary. Lack of resources or difficulty of administration should prevent eligibility criteria that are either overly generous or overly complex. It may be both difficult and costly, for example, to monitor eligibility of the unemployed who are not currently receiving unemployment compensation. States that choose to assume this burden could be required to pay any additional administrative cost that such eligibility standards entail.

The Source of Federal Financing

We would urge the Subcommittee to oppose the Administration's proposal to use revenue gained from taxes on employer paid health insurance to finance this program. We are convinced that such taxation is a bad idea, for at least four reasons. First, tax cap revenues would be an unpredictable, unreliable source of funds. If such taxes were to achieve their primary intent, to encourage employers to build more cost-sharing into their benefit packages to bring expenditures under the cap amount, the tax will not generate sufficient revenues to finance this or any other program.

Second, unless the level of the cap is regionally adjusted, which is administratively difficult, the tax burden will fall most heavily on the higher cost areas of the country — which usually are those already suffering the highest levels of unemployment! Moreover, in any region of the country, employers that offer good continuation coverage for laid-off workers will be discouraged from doing so, for the cost of such continuation coverage is usually built into the rates for the regular group policy.

Third, our experience suggests that creating a lid on employer based health insurance spending will cause employers to cut their health benefits budget in two critical areas (and probably shift their costs to other non-taxed fringe benefits). Coverage for preventive services and ambulatory care service coverage will be cut in favor of retaining maximum coverage for inpatient care. People will be encouraged to seek inpatient care when outpatient service would have been as effective and much more cost-efficient. Alternatively, employers can cut their benefits budgets by adding large front-end deductibles and copayments to the benefit package. This action will place an especially heavy burden on the lower income worker who is least able to pay these cost sharing amounts or to independently purchase supplemental coverage to protect against their occurrence.

And fourth, employers whose health benefit programs exceed the cap may respond by both retaining their current program and offering an alternative lower-cost, lower protection program. Such a choice situation will inevitably prompt the "adverse selection" spiral we mentioned above. That is, the younger, healthier employees segregate themselves from the older, less healthy employee; the risk of illness is no longer spread across the entire group; the more comprehensive package rapidly escalates in cost — to the point where there is no real insurance at all.

We do not presume to tell you what the best source of Federal revenues for this program would be, but we think we know what the worst source would be — a tax on employee health benefits!

Blue Cross and Blue Shield Plan Programs

In the course of these comments I have alluded to a number of programs underway by Blue Cross and Blue Shield Plans. In addition to the program in Western Pennsylvania, which has been discussed, I would like to conclude by briefly describing two other Plan programs.

An interesting program is now underway in Charleston, West Virginia. The Charleston Blue Cross and Blue Shield Plan developed a limited hospital benefit for the United Mine Workers Union. The benefit was originally designed to protect workers during the recent UMW strike. The Union, pleased with the security offered by the benefit asked the Charleston Plan and other Plans that administer this account to make this coverage available to miners who have exhausted their health and welfare benefits due to layoffs. It now appears that other unions are looking into this benefit concept. As an impressive footnote, the Charleston Plan has had a number of calls from local charitable organizations volunteering to help union members pay the minimal monthly premium.

In Southwestern Virginia the Blue Cross and Blue Shield Plan has recently announced a program called Term Reserve. It provides outpatient and inpatient hospital and physician services without limit for a 12 month benefit period. Each person would be protected for up to \$1 million against the cost of catastrophic illness or injury. The premium for this coverage is \$77.39 per month for a family, \$50.67 for an individual with a dependent child and \$33.37 for an individual.

In many parts of the country, physician organizations, community groups and health care providers have rallied to assist the unemployed worker secure necessary care. We do not doubt that legislative assistance would greatly help communities where such volunteerism does not now exist. However, it would be unfortunate if the availability of such assistance reduced volunteer and private market efforts.

Mr. Chairman and Members of the Subcommittee, I appreciate this opportunity to share our ideas and concerns with you. I encourage you to consider our suggestions and to call on us if we can be of assistance to your staff in this important policy development process.

Senator QUAYLE. Thank you very much.

Does anybody have a price tag on what a minimum benefits package would cost?

Ms. LEHNHARD. We have done some rough estimates on what a minimum benefits package might cost. Our Pennsylvania plan, Blue Cross and Blue Shield of Western Pennsylvania, has a very limited in-patient and out-patient program. It is somewhat subsidized, but the premiums run about \$60 per month. We would have to provide you with information on what an unsubsidized plan might cost.

Senator QUAYLE. So, what would that be nationwide?

Ms. LEHNHARD. We would have to do those calculations for you. We would be glad to supply some estimates.

Mr. TROY. I would assume, as Ms. Lehnhard said, that for this group taking into account adverse selection and maybe some health care being let go for a while, that you would be very unlikely to get away with much less than \$1,000 per family per year. So you can take \$1,000 and multiply it by the number of people. If you have 2 million people, you have \$2 billion, and so forth. That is about how our numbers would run.

Senator QUAYLE. I was just told by staff that the Waxman plan comes out to about \$250 per person. Is that a fairly accurate figure?

Mr. TROY. Per person? That would be per family, \$750? That would be a very inexpensive plan, \$250 a year per family; I will say that. It would be a very thin plan.

Ms. LEHNHARD. In addition to the generosity of your benefits, a real variable is what type of people enroll in the program. If it is the very sickest, premiums would be much higher than if there were a broad representation of the people in a community.

Senator QUAYLE. Do you have data that shows that there has been a significant decline in people who have health insurance today?

Mr. TROY. I think the total numbers are not declining, but of course, you have an increased population and a greater number of people within the potential work force.

Senator QUAYLE. Percentages of work force, has that declined for percentage of population?

Mr. TROY. I would say there has been an erosion in the number of people covered as a percentage of the population in the last few years, yes.

Senator QUAYLE. Do you have any idea of what that is? Does anybody have those statistics?

Mr. TROY. I think—and Marty can correct me if I am wrong—but I think that the numbers covered by private insurance have stayed fairly steady at about 165 million, and considering the growth in the population, and the cutbacks in medicaid, that is, thousands of people let off the medicaid rolls, so I think you have that difference. Growth in the population and reduction in medicaid accounts for the difference in the number of people who are without coverage.

Mr. DICKLER. One of the problems, Senator, is that these numbers are compared to very large numbers. When you talk about 165 million covered people to begin with, and then you try to measure the true number who have no insurance, which might be 2, 3, or 4 million, it is very difficult to get a precise measure of the change you are talking about.

Senator QUAYLE. Earlier, one of the witnesses from NAM indicated that there ought to be a requirement to have employers have an additional 90 days' coverage for the employees once they are laid off. Is there a price tag what that would be? Does anybody know the additional cost that would be to the employer to have people continue for 90 days, or any idea?

Mr. TROY. I would say that depends on the extent of the employees' contribution. If there were no laid-off employee contributions, then I would come back to your \$1,000 per person per year, and that means it would cost \$250, I guess, for 3 months and \$500 for 6 months, if this group is not significantly worse than the active employee group. I agree with Ms. Lehnhard that this would be not as good a group, perhaps, as the active employee group, in terms of who would come into the plan.

Senator QUAYLE. Well, thank you for coming today. We certainly look forward to working with you.

At this point I order printed all statements of those who could not attend and other pertinent material submitted for the record.

Senator QUAYLE. Thank you very much, and that concludes the hearings today.

[Whereupon, at 1:03 p.m., the subcommittee was adjourned.]

[The material referred to follows:]



Federation of American Hospitals

Michael D. Bromberg, Esquire, Executive Director

National Offices 1111 19th Street, N.W., Suite 402

Washington, D. C. 20036 Telephone 202 / 833-3090

May 2, 1983

The Honorable Dan Quayle
 Chairman
 Subcommittee on Employment and
 Productivity
 Committee on Labor and Human Resources
 United States Senate
 Washington, D.C. 20510

Dear Mr. Chairman:

I wish this statement to be included in the printed record of the Committee's hearings on health insurance for the unemployed.

The Federation of American Hospitals wishes to express its support for legislation ensuring greater access among the unemployed to private health insurance coverage. This short term critical problem should be addressed by the Congress, however, it does not call for the enactment of a new broad federally financed, and administered regulatory program. Given the pending insolvency of the Medicare Hospital Insurance Trust Fund and the current federal deficit a new source of financing any proposal is essential.

We believe that adequate access to insurance for the unemployed can best be achieved by requiring employers to provide continuation of insurance coverage beyond termination of employment and mandating an open enrollment period to enroll unemployed spouses. Employer plans not providing such coverage should lose a portion of their tax deductibility of insurance premiums. The Federation supports a tax cap on all employer paid premiums and urges that additional revenues gained from the cap be targeted to provide funding for those not covered through the purchase of continued private coverage.

The Federation supports the provisions in S. 951 allowing States to require cost sharing by beneficiaries for services as well as the provisions in both S. 951, S. 811 and H.R. 2552 allowing financing of premiums up to a certain percentage of the beneficiaries unemployment insurance payment.

We look forward to working with members of this committee in developing an effective response to the needs of the uninsured unemployed.

Sincerely,

Michael D. Bromberg
 Michael D. Bromberg
 Executive Director



National Association
of Manufacturers
Industrial Relations Department

June 23, 1983

The Honorable Dan Quayle
United States Senate
524 Hart Senate Office Building
Washington, DC 20510

Dear Senator Quayle:

NAM testified before the Subcommittee on Employment and Productivity/Labor and Human Resources Committee on May 3, 1983, on health insurance for the unemployed. At that time we offered a private sector approach to handle the problem. Specifically, we recommended that health insurance coverage of an employed spouse be made available to laid-off family members and that employers extend health insurance coverage for 90 days after lay-off.

Determining a specific dollar amount for this proposal is problematic since there are no accurate data reporting what portion of the 10.6 million unemployed would utilize this coverage. If, however, one assumes a one percent lay-off of those expected to be employed in 1984, we estimate that our recommendation could cost approximately \$6 billion. We ask that you consider this number as a very rough estimate at this time.

Thank you again for the opportunity to present our views on this issue.

Sincerely,

Sharon F. Canner
Analyst, Health Care
Employee Benefits



Congressional Research Service
The Library of Congress

Washington, D.C. 20540

April 29, 1983

TO : Senate Labor Subcommittee on Employment
Attention: Bob Guttman

FROM : Jennifer O'Sullivan
Specialist in Social Legislation
Education and Public Welfare Division

SUBJECT : Material on Potential Barriers to Medicaid Eligibility
for the Unemployed

Potential Barriers to Medicaid Coverage for the Unemployed

The attached material is in response to your request for an outline of the major eligibility criteria which may prevent unemployed persons from obtaining Medicaid coverage.

Medicaid eligibility for families is tied to actual or potential receipt of cash assistance under the Aid to Families with Dependent Children (AFDC) program. ^{1/} Single persons and childless couples can never gain AFDC or Medicaid eligibility. Similarly, intact families are generally unable to obtain program benefits. Certain States have elected to extend AFDC coverage and, therefore, Medicaid to intact families where the principal breadwinner is unemployed. A number of additional States have elected to provide Medicaid coverage to families with unemployed parents or just the children in such families. [See Table 3].

^{1/} Eligibility may also be tied to actual or potential receipt of Supplemental Security Income (SSI); however, this does not generally affect the unemployed.

Persons meeting the so-called "categorical" criteria for coverage under AFDC or Medicaid are also required to meet certain income and resource standards. Tables 1 and 2 ^{2/} outline by State the effective gross earned income limits (not payment levels) for AFDC coverage; these are the maximum gross earnings that a family could have and still receive an AFDC payment. Individuals meeting the income criteria are also required to meet resource criteria. By Federal law and regulation, the resource limit for real and personal property cannot exceed \$1,000 equity value per family unit. The State must exclude from this calculation the family's home and up to \$1,500 equity value in an automobile. A State is also permitted but not required to exclude basic maintenance items essential to day-to-day living such as clothes and furniture.

Some families may meet the State-established "categorical" requirements but have incomes and/or assets in excess of the State's cash standards. These persons may qualify for so-called medically needy coverage if: a) the State has established a medically needy program, and b) their income, after deducting incurred medical expenses, falls below the State's standard. The income standard cannot exceed 133 1/3 percent of the State's maximum payment amount (applicable for a comparable size family with no other income) under AFDC. Table 4 shows the medically needy income levels in States having such programs; Table 5 lists those States without such programs. This information is based on the latest information available to us through the "Medicare and Medicaid Guide" published by the Commerce Clearing House. It should be noted the income levels reported in this chart are generally lower than the amounts appearing in Tables 1 and 2. Tables 1 and 2 reflect maximum gross income amounts which a family could earn and still receive a cash payment. The medically needy levels are those amounts

^{2/} Data calculated by CRS based on material supplied by the Department of Health and Human Services.

which are used for medically needy determinations after all the appropriate income disregards have been calculated.

States may apply the same resource tests for their medically needy populations as are applied under their AFDC programs. Alternatively, they are permitted to establish more generous standards provided they are reasonable. Many States having medically needy programs have standards which are slightly more generous than that under their AFDC programs.

Attachment

TABLE 1. Monthly Earned Income Limits--AFDC Mother and 2 Children, with Child Care Costs of \$100 1/(Assumes that mother does not receive the Earned Income Tax Credit [EITC]) 2/

	First 4 months on job (no EITC)	After 4 months on job (no EITC)	Gross income limit at all times--150% of need standard
Alabama.....	\$ 367	\$ 283	\$ 576
Alaska.....	921	779	921
Arizona.....	349	349	349
Arkansas.....	351	305	351
California.....	759	671	759
Colorado.....	582	553	582
Connecticut.....	769	678	769
Delaware.....	399	399	399
District of Columbia.....	640	465	879
Florida.....	503	374	600
Georgia.....	481	359	549
Hawaii.....	702	633	702
Idaho.....	647	470	831
Illinois.....	643	467	729
Indiana.....	460	441	460
Iowa.....	621	525	621
Kansas.....	546	529	546
Kentucky.....	282	282	282
Louisiana.....	475	355	757
Maine.....	672	613	672
Maryland	559	460	559
Massachusetts.....	597	563	597
Michigan (Washtenaw Co.). (Wayne Co.).....	792 (747)	648 (620)	792 (747)
Minnesota.....	669	611	669
Mississippi.....	420	385	429
Missouri.....	468	426	468
Montana.....	601	497	601
Nebraska.....	525	515	525
Nevada.....	427	395	427
New Hampshire.....	489	489	489

See footnotes on next page.

TABLE 1. Monthly Earned Income Limits--AFDC Mother and 2 Children, with Child Care Costs of \$100 ^{1/} (continued)(Assumes that mother does not receive the Earned Income Tax Credit [EITC]) ^{2/}

	First 4 months of Job (no EITC)	After 4 months of Job (no EITC)	Gross income limit at all times--150% of need standard
New Jersey.....	\$-540	\$ 525	\$ 540
New Mexico.....	349	349	349
New York (Suffolk Co.)..	760	672	760
(New York City)....	(636)	(589)	(636)
North Carolina.....	493	367	606
North Dakota.....	385	385	385
Ohio.....	584	428	733
Oklahoma.....	423	423	423
Oregon.....	507	503	507
Pennsylvania.....	525	515	525
Rhode Island.....	682	620	682
South Carolina.....	280	280	280
South Dakota.....	481	481	481
Tennessee.....	268	268	268
Texas.....	252	252	252
Utah.....	876	749	876
Vermont.....	949	671	1,101
Virginia.....	516	475	516
Washington.....	866	616	1,038
West Virginia.....	412	371	412
Wisconsin.....	888	668	888
Wyoming.....	540	525	540
Guam.....	382	382	382
Puerto Rico.....	240	165	240
Virgin Islands.....	313	313	313
(Marye Co.).....			
Minnesota.....			

^{1/} The calculated monthly earned income limits (columns 1 and 2) are below 150 percent of the need standard (column 3) in 12 jurisdictions during the first 4 months of a job and in 41 jurisdictions thereafter. In these jurisdictions higher child care costs would increase the earned income limits. However, the maximum additional child care deduction would be \$220, since the law imposes a ceiling of \$160 per child. An extra dollar spent on child care would increase the earnings limit by \$1, provided this did not push the limit above the absolute ceiling, 150 percent of the need standard.

^{2/} Amounts shown in columns 1 and 2 would be smaller if mother received

TABLE 2. Monthly Earned Income Limits--AFDC Mother and 2 Children, with Child Care Costs of \$100 1/

(Assumes that mother receives the Earned Income Tax Credit [EITC])

	First 4 months of Job (with EITC)	After 4 months of Job (with EITC)	Gross income limit at all times--150% of need standard
Alabama.....	\$ 333	\$ 257	\$ 576
Alaska.....	921	771	921
Arizona.....	317	317	349
Arkansas.....	319	277	351
California.....	749	648	759
Colorado.....	546	513	582
Connecticut.....	760	656	769
Delaware.....	363	363	399
District of Columbia....	613	423	879
Florida.....	461	340	600
Georgia.....	439	327	549
Hawaii.....	683	605	702
Idaho.....	621	428	831
Illinois.....	616	425	729
Indiana.....	418	401	460
Iowa.....	591	483	621
Kansas.....	505	487	546
Kentucky.....	257	257	282
Louisiana.....	433	323	757
Maine.....	649	582	672
Maryland.....	520	418	559
Massachusetts.....	563	525	597
Michigan (Washtenaw Co.)	786	622	792
(Wayne Co.).....	(735)	(590)	(747)
Minnesota.....	646	579	669
Mississippi.....	382	350	429
Missouri.....	426	388	468
Montana.....	568	455	601
Nebraska.....	483	473	525
Nevada.....	389	359	427
New Hampshire.....	447	447	489

See footnotes on next page.

TABLE 2. Monthly Earned Income Limits--ADFC Mother and 2 Children, with Child Care Costs of \$100 ^{1/} (continued)

(Assumes that mother receives the Earned Income Tax Credit [EITC])

	First 4 months of Job (with EITC)	After 4 months of Job (with EITC)	Gross income limit at all-- times--150% of need standard
New Jersey.....	\$ 498	\$ 483	\$ 540
New Mexico.....	318	318	349
New York (Suffolk Co.)..	750	649	760
(New York City)....	(608)	(554)	(636)
North Carolina.....	451	334	606
North Dakota.....	350	350	385
Ohio.....	549	389	733
Oklahoma.....	385	385	423
Oregon.....	465	461	507
Pennsylvania.....	483	473	525
Rhode Island.....	661	590	682
South Carolina.....	255	255	280
South Dakota.....	439	439	481
Tennessee.....	244	244	268
Texas.....	229	229	252
Utah.....	876	737	876
Vermont.....	949	648	1,101
Virginia.....	474	433	516
Washington.....	866	585	1,038
West Virginia.....	375	338	412
Wisconsin.....	888	645	888
Wyoming.....	498	483	540
Guam.....	<u>2/</u>	<u>2/</u>	382
Puerto Rico.....	<u>2/</u>	<u>2/</u>	240
Virgin Islands.....	<u>2/</u>	<u>2/</u>	313

^{1/} The calculated monthly earned income limits (column 1 and 2) are below 150 percent of the need standard (column 3) in 48 jurisdictions during the first 4 months of a job and in all jurisdictions thereafter. In these jurisdictions higher child care costs would increase the earned income limits. However, the maximum additional child care deduction would be \$220, since the law imposes a ceiling of \$160 per child. An extra dollar spent on child care would increase the earnings limit by somewhat less than \$1 in low-benefit States, but by more than \$1 in some high-benefit States, provided this did not push the limit above the absolute ceiling, 150 percent of the need standard.

^{2/} EITC is not available in the outlying areas.



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TABLE 3. Medicaid Coverage of Families Where Principal Breadwinner is Unemployed

a. State Has AFDC/UP Program; Medicaid Coverage Automatic for Those Receiving AFDC a/

California	Minnesota
Colorado	Nebraska
Connecticut	New Jersey
Delaware	New York
District of Columbia	Ohio
Hawaii	Pennsylvania
Illinois	Rhode Island
Iowa	Vermont
Kansas	West Virginia
Maryland	Wisconsin
Massachusetts	Guam
Michigan	Northern Mariana Islands

b. State Provides Medicaid Coverage Only (No AFDC/UP Program) b/

Kentucky
Maine

c. State Only Provides Medicaid Coverage to Children in Families with Unemployed Breadwinner (Parents not Covered) b/

Arkansas	Oregon
Indiana	Utah
Missouri	Puerto Rico
Oklahoma	Virgin Islands

a/ Data as of December 1982, supplied by Department of Health and Human Services.

b/ Data from Commerce Clearing House, "Medicare and Medicaid Guide," updated through March 1983.

Jennifer O'Sullivan
Specialist in Social Legislation
Education and Public Welfare Division
April 29, 1983



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TABLE 4. Medicaid Medically Needy Coverage Monthly Income
Levels Protected for Maintenance for Three Person Family

Arkansas	\$191.67	Nebraska	450.00
California	506.00	New Hampshire	346.00
Connecticut		New York	516.67
Region A	516.67	North Carolina	275.00
Region B	441.67	North Dakota	435.00
Region C	433.33	Northern Mariana Islands	245.00
District of Columbia	453.10	Oklahoma	423.00
Guam	233.33	Pennsylvania	391.67
Hawaii	475.00	Puerto Rico	475.00
Illinois	302.00	Rhode Island	525.00
Kansas	420.00	Tennessee	169.00
Kentucky	258.33	Utah	509.00
Louisiana		Vermont	
Urban	258.00	Chittenden County	495.00
Rural	233.00	Rest of State	477.00
Maine	433.33	Virgin Islands	333.33
Maryland	325.00	Virginia	
Massachusetts	435.00	Group 1	258.33
Michigan (11 scales)		Group 2	283.33
highest	480.00	Group 3	333.33
lowest	453.00	Washington	497.00
Minnesota	446.00	West Virginia	233.00
Montana	400.00	Wisconsin	592.00

Source: "Medicare and Medicaid Guide," Commerce Clearing House, updated through March 1983; and conversation with Health Care Financing Administration official.

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Specialist in Social Legislation
Education and Public Welfare Division
April 29, 1983



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TABLE 5. States Not Having Medically Needy Programs

Alabama	Missouri
Alaska	Nevada
Arizona	New Jersey
Colorado	New Mexico
Delaware	Ohio
Florida	Oregon
Georgia	South Carolina
Idaho	South Dakota
Indiana	Texas
Iowa	Wyoming
Mississippi	

in.
Source: "Medicare and Medicaid Guide," Commerce Clearing House

Jennifer O'Sullivan
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Education and Public Welfare Division
April 29, 1983

HEALTH CARE FOR DISPLACED WORKERS ACT OF 1983

MONDAY, MAY 9, 1983

U.S. SENATE,
SUBCOMMITTEE ON EMPLOYMENT AND PRODUCTIVITY
OF THE COMMITTEE ON LABOR AND HUMAN RESOURCES,
Washington, D.C.

The subcommittee met, pursuant to notice, at 9:55 a.m., in room 628, Dirksen Senate Office Building, Senator Dan Quayle (chairman of the subcommittee) presiding.

Present: Senators Quayle, Hawkins, Nickles, and Metzenbaum.

Senator QUAYLE. The committee will come to order. This is our second day of hearings on health insurance for the unemployed. We're delighted to welcome the Director of OMB, David Stockman. We appreciate that you have come before the committee, and also appreciate your accommodation. We had originally scheduled this for Friday, and now it's scheduled for today. Thank you for you re-arranging your schedule.

I have really no opening statement. I don't believe Senator Metzenbaum does, and nor does Senator Hawkins or Senator Nickles, so, Mr. Stockman, why don't you go ahead.

STATEMENT OF HON. DAVID A. STOCKMAN, DIRECTOR, OFFICE OF MANAGEMENT AND BUDGET

Mr. STOCKMAN. Thank you very much, Mr. Chairman.

I'm pleased to appear before your subcommittee. I have a quite lengthy statement that I believe we filed with the committee last week which attempts to analyze the dimensions of the problem as we see it. It lays out the conclusions that we've come to, and the basis for the recommendations that we have made for Federal action in this area of providing health benefits coverage continuity for the unemployed.

So, with your permission, I would like to submit this for the record and try to summarize about half a dozen points of highlight that, I think, will help the committee understand the kinds of recommendations that we've made.

Senator QUAYLE. OK. The entire testimony will be inserted in the record.

Mr. STOCKMAN. Mr. Chairman, if I were to briefly summarize our conclusions and recommendations, I would suggest that our major conclusion is that lack of access to health insurance or affordable health care is not a systematic or generic condition among the unemployed. But at the same time, serious hardship does exist for se-

lective groups, and that hardship warrants a Federal response and Federal action.

Moreover, we would conclude that lack of ready availability of coverage to many of the unemployed is a greater problem than affordability of protection, and we would recommend some steps to remedy that problem as well.

We would therefore recommend that the committee avoid a sweeping generic solution, and by that I mean a uniform medical entitlement for the unemployed, and pursue, instead, a multipronged strategy that carefully addresses the heterogeneous problems that actually exist in the various localities around the country.

The first element of that multipronged strategy that we have recommended to the Finance Committee and that we're now recommending to your subcommittee would be broadened family health protection through mandatory open enrollment for working spouses.

By our calculations 3.3 million, or nearly 30 percent of those who experienced unemployment in the recession peak first quarter of 1983—that would be January through March, the worst we hope of the recession level of unemployment—had working spouses, and another 2.4 million of those who were unemployed were dependents who lived in intact families with one or more other working members.

Thus, overall, 5.7 million, or nearly 50 percent of those who experienced unemployment during the first quarter recession peak, were in multiple worker families with a high probability of employer coverage available to at least one member of the family.

Therefore, by mandating open enrollment, so that the entire family can be protected by the policy of the remaining working member, a significant proportion of the financial and health threat to the temporarily unemployed can be alleviated.

The second element of our recommendation concerns broadened access to continuation coverage for those who are laid off. Here, I would suggest to the subcommittee that we confront an anomalous juxtaposition of facts. On the one hand, significant proportions of the unemployed have both short spells of unemployment, and/or relatively high family incomes.

In 1981, for example, 44 percent of the unemployed had family incomes in excess of \$20,000 per year, and the average family income was \$20,500 for unemployed married men, and \$24,150 for families with unemployed married women.

Second, the average spell of unemployment lasted only 14.3 weeks in the recession year of 1982, and 41 percent of all unemployment spells lasted less than 4 weeks.

From both vantage points, the problem among this segment, and admittedly, this is a limited, but large and important segment of the unemployed, the problem among this segment, those with relatively high income, or short spells of unemployment, is not lack of income, or affordability, but availability of reasonably priced temporary coverages that they could afford from their own resources and that would provide them with protection during the spell of unemployment.

On the other hand, the underlying dynamic and structure of our health insurance system in the private sector is preponderantly workplace-based and group rated plans, and this works a needless hardship or injustice in the case of this segment of the unemployed that I've just defined.

Families with incomes and incentives to buy temporary coverage find it difficult to obtain due to the high cost of individual policy retailing, sometimes double the cost for equivalent coverage under group plans, or due to disqualification for preexisting medical conditions as a result of losing group coverage and starting all over from scratch, more or less, or due to adverse risk premiums that are apparently built into individual policies that are marketed outside the employer-based group system.

Therefore, we suggest that this mismatch of relative ability to pay and relative unavailability of reasonably priced coverage be alleviated with two continuity of benefit mandates that would become part of the tax law, and therefore part of the qualification for tax deductibility and tax excludability of employer health benefits.

The first would be the right to purchase the existing employer plan for up to 12 months after termination or until reemployment, whichever comes earlier. And the second would be the right to purchase from the employer's carrier, insurance carrier, an alternative low cost catastrophic type plan at the option of the terminated or laid off employee.

Now, let me stress in the case of both of these recommendations for changes to the tax law, and therefore mandated options, this would not involve either a Federal or employer subsidy, but it would permit the temporarily unemployed to buy into the mainstream of relatively cheaper, employer-based coverage system. I think this is the heart of the recommendation regarding continuity of coverage. You essentially have a dual system of private health insurance coverage out there now. The groupbased, workplace-based system that covers most employees, that takes advantage of economies of scale in retailing and administration, that pools risks, and even though it's expensive in some absolute sense, it is relatively inexpensive, compared to the other system which is out there, the individually marketed, individual plan, with very high retailing cost, with a tendency toward adverse risk embodied in the premium, and beyond the reach of many families, even those that have income during their period of unemployment.

And our basic recommendation is to provide a way for those who are temporarily unemployed to buy into that first system at reasonable rates, rather than being left to search among the individual plans that contain sometimes impossible conditions or cost.

Finally, Mr. Chairman, and members of the committee, we recognize that not all of the unemployed are members of households with other workers and that a segment of the unemployed consists of those who face serious hardship due to long or multiple spells of unemployment, or due to exhaustion of UI coverage, and of other family resources.

Here we recommend two steps: First, that a block grant for medical coverage in hardship cases be developed. We have recommended that this be provided through the title XX mechanism with

broad State discretion as to who is covered, what type of benefits would be provided, conditions of eligibility, and so forth.

And second, and an integral part of this recommendation, is that any increase in budget resources for block grants distributed to the States to provide assistance in these hardship cases be financed on a pay-as-you-go basis.

We have recommended specifically that each dollar of increased cost through the block grants, and approved by the Congress, be financed in the form of a dollar-for-dollar increase in the cap on the exclusion of health benefits that we have recommended in the 1984 budget.

We would estimate, for instance, that if the committee chose a \$500 million level of block grant funding, that it would require a tax cap of \$160 per month on the family benefit side in order to generate dollar for dollar, pay-as-you-go financing to fund this program.

Mr. Chairman, let me conclude by stressing two important aspects of our recommendation. The first is that we strongly oppose and cannot in any way accept a new across-the-board entitlement providing medical benefits for the unemployed, particularly one that is not means tested and, therefore, would make eligible a broad segment of the middle class for temporary periods and would become impossible to finance in our view over time, given the magnitude of the budget deficits that we face already.

I would point out in that regard that in the budget that we are struggling with at the present time there is already 2.2 trillion dollars' worth of entitlement costs—medical, retirement, low-income entitlements, the whole set of entitlements combined—built in under current law over the 5-year horizon in the budget on which we're now working.

And nevertheless, in the face of that \$2.2 trillion in built-in cost, the Senate Budget Committee, after very extensive and detailed discussion, was only able to recommend to the full Senate \$24 billion in new savings beyond those already enacted in the social security bill and in the medicare prospective reimbursement portion of that bill.

What I'm saying is that the Senate Budget Committee was able to find savings equal to only 1 percent of the \$2.2 trillion already built in, and that ought to be warning enough in itself that we can't afford another entitlement as we struggle to pay for those that we already have in the face of massive and enduring deficits.

The other point I would make here is that given the skyrocketing costs of medicare and medicaid alone, even the largest economy in the world cannot afford a third exposure to a third major medical entitlement program. As many of the members of this committee I'm sure are aware, medicare, itself, is headed for bankruptcy sometime in the 1987-89 timeframe, and it will require a massive legislative fix capable of generating some \$600 billion in additional financing to keep the system solvent from that point through the end of the 1990's or the turn of the century.

Now, with a \$600 billion financing gap or shortfall already facing us in medicare, with the type of overall deficit that we're struggling to reduce, with a built-in entitlement baseline cost of over \$2 trillion that we can find very little room to trim, then it is very

clear to me that it would be an enormous and irreversible fiscal mistake to start a third entitlement as we seek to grapple with this problem.

As I said to the Committee on Finance, and I will repeat again to your subcommittee today, Mr. Chairman, for all practical purposes, the Federal Government is insolvent already, with built-in expenditures exceeding current law revenues by over \$1 trillion in the next 5 years. And therefore, any new money that we decide to spend for any new program, no matter how meritorious, must be tax financed in the same bill that creates the expenditure.

And therefore, and that is why that we insist, as a bottom line, that any proposal that we finally generate to deal with this problem be strictly based on the pay-as-you-go principle, and, more importantly, that it be crafted and tailored to the magnitude of the problem that actually exists along the lines that we've recommended to Congress.

That concludes my overall summary of what we've recommended, Mr. Chairman, and I would be very happy to take your questions and the questions from the members of the committee.

[The prepared statement of Mr. Stockman follows:]



EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
WASHINGTON, D.C. 20503

Embargoed for Release
Upon Delivery
Expected 10:00 AM

STATEMENT OF THE HONORABLE DAVID A. STOCKMAN
DIRECTOR, OFFICE OF MANAGEMENT & BUDGET
BEFORE THE
SUBCOMMITTEE ON EMPLOYMENT AND PRODUCTIVITY
COMMITTEE ON LABOR AND HUMAN RESOURCES
UNITED STATES SENATE

May 9, 1983

MR. CHAIRMAN:

Thank you for the opportunity to appear before your Committee today to discuss the problem of health insurance for the unemployed. As you well know, the Administration has made an systematic study of this issue over the past few weeks. I come before you today to share with you the conclusions the Administration has reached as a result of that study, and to outline the Administration's views of appropriate -- and inappropriate -- remedies to address it.

Summary of Recommendations

Our primary conclusion, Mr. Chairman, is that the problem of lack of health insurance among the unemployed is one of selective gaps and discontinuities -- and not a pervasive or general problem. As I will discuss in more detail shortly, the number of long-term unemployed who are wholly without access to health care services is really a limited subset of the unemployed. The Administration believes that the needs of this group can be met by a package of policy reforms such as the following:

- Requirements for employer insurance packages that ensure the unemployed access to continued coverage when they become unemployed.
- Requirements for employer insurance packages to ensure that the unemployed can be enrolled under a working spouse's health plan should they become unemployed and lose their own employer coverage,
- Amendments to the Social Services Block Grant Act to provide that funds available to the States can be used to fill in whatever gaps in coverage remain; and
- "Pay as you go" financing for any additional funding under title XX through enactment of the Administration's proposed limits on tax exclusion of employer insurance contributions at a level below that originally proposed.

Defining the Problem Carefully

Our support for these measures -- and our belief that these steps will be more than adequate to address health coverage problems among the unemployed -- is based on our study of the access of unemployed Americans to health care services. The general perception, Mr. Chairman, is that all unemployed American families somehow confront common problems due to the misfortune of unemployment. We have concluded, however, for the reasons discussed below, that lack of access to adequate health care is not a generic problem associated with unemployment, per se, and that in fact the great majority of the unemployed are not being denied care.

Continuation and Conversion Privileges

The truth is that many employers presently provide extended coverage to workers who are on layoff. In many cases, such coverage extensions are benefit plan features obtained as a result of collective bargaining. In other instances, employers offer coverages of this sort unilaterally. In any event, most insurance plans, enrolling workers as they do on a month-to-month basis, cover laid-off workers at least until the end of the month in which they are terminated. Such automatic extensions can provide up to four weeks of additional coverage even if there is no employer-financed extension. Many families use this remaining eligibility to actually obtain medical services family members may need.

Additionally, a number of States provide, as a matter of law, that workers may continue to enroll in a health insurance plan. In 12 States, employers are required to offer continued coverage to former employees at group insurance rates. In 11 States, employees must be offered the option of converting to individual health insurance plans. While these practices require laid-off workers to finance coverage out of their own resources, families with significant medical expenses at the time of termination are provided the means to limit their exposure without regard to pre-existing medical conditions. In most such instances, these features provide considerable protection.

Range of Unemployment Duration

Even in instances where employers do not continue health insurance for laid-off workers, several pieces of available data suggest that the problem is not as large as is commonly perceived.

The best available evidence is that even during economic recessions the labor force is a dynamic one and duration of spells of unemployment for most unemployed individuals remains relatively brief.

TABLE I

PERCENTAGE DISTRIBUTION OF UNEMPLOYMENT SPELLS				
	<u>Short</u>	<u>Medium</u>	<u>Long</u>	<u>Average</u>
	<u>(1-4 weeks)</u>	<u>(5-26 weeks)</u>	<u>(27+ weeks)</u>	
1982	41%	48%	11%	14.3
1978	49%	46%	5%	8.3

In 1982, the worst year for unemployment since World War II, the average spell of unemployment lasted just over three months. Although the average unemployment spell was much longer than it was during a non-recession year such as 1978, it was still the case in 1982 that two out of every five spells of unemployment lasted for less than one month.

Although many individuals experienced more than one spell of unemployment during 1982, the data still reveal that for most Americans unemployment is a temporary phenomenon. Long-term unemployment, which results in a severe strain on family resources, tends to be concentrated on a small but significant portion of Americans. But even during the most difficult economic times, such as last year, only 11 percent of all spells of unemployment lasted longer than six months.

Family Resources

Despite the vast array of social welfare programs, the family remains the primary social institution that cushions individuals from the financial hardship of unemployment. We often tend to view the unemployed, especially those with long durations of unemployment, as a homogeneous group in need of financial assistance. In fact, the family provides the main source of financial assistance for the unemployed. Although data for 1982 are not available yet, data for 1981 provide some indication of the financial resources of the unemployed in a recession year.

TABLE II

FAMILY INCOME OF THE UNEMPLOYED IN 1981

	<u>Total</u>	<u>Duration of Unemployment:</u>	
		<u>Short-term</u> (1-4 weeks)	<u>Long-term</u> (26+ weeks)
Average Family Income....	\$20,898	\$23,113	\$17,035
Percent with Family Income Greater Than \$20,000....	44%	51%	33%
Percent with Family Income Below Poverty.....	19%	14%	31%

As the data in the accompanying table indicate, the financial circumstances of the unemployed vary enormously. In 1981, for example, 44 percent of all unemployed individuals lived in families with incomes in excess of \$20,000.

On the other hand, 31 percent of all individuals experiencing six months or more of unemployment lived in poverty, while over one-third of the long-term unemployed lived in families with incomes in excess of \$20,000.

Of course, even families with substantial resources can experience cash flow difficulties that compel them to use their savings to tide them over spells where one family member is unemployed. But we should not conclude that such families will be unable to afford either health insurance coverage or actual medical expenses simply by reason or length of unemployment.

Coverage Through Working Spouses

The primary reason that family incomes remain relatively high among many of the unemployed is the presence of secondary earners in the household. In 1981, over 80 percent of the average family income among the unemployed represented earnings of family members. Although the 1981 data may not be representative of current conditions, the most recent statistics for the first quarter of 1983 indicate that the proportion of unemployed family members who have other family members working remains high. Among all unemployed individuals in families, 65% have other family members at work.

Besides providing an additional source of income, working family members are also a potential source of health insurance coverage for the unemployed. While data on family coverage among secondary workers is unavailable, many have held insurance coverage through their employer.

Some idea of the size of the non-covered unemployed population can be obtained by a close inspection of family characteristics among unemployed individuals:

TABLE III

CHARACTERISTICS OF THE UNEMPLOYED, 1983:I	
Family Type	Millions of Individuals
1) <u>Total Unemployed in Families</u>	10.5
<u>Intact Families</u>	
2) Married Persons with Working Spouse.....	3.3
3) Dependents with Working Family Member.....	<u>2.4</u>
4) Sub-Total.....	5.7
<u>Single-Parent Potential Medicaid Families</u>	
5) Female-headed.....	2.1
6) Male-headed.....	<u>0.6</u>
7) Sub-Total.....	2.7
8) <u>Unemployed Sole Wage Earners</u>	2.1

As is indicated in the accompanying table, 10.5 million individuals living in families experienced some unemployment during the first quarter of 1983. Among the 5.2 million unemployed married persons, 3.3 million had working spouses. Unemployed husbands with working wives represented just over half of this group. Also, unemployed relatives in intact families with a working husband or wife numbered 2.4 million over the period. Therefore, of the 10.5 million unemployed individuals, 5.7 million lived in intact households with at least one parent employed, and hence were potentially eligible for coverage.

In addition, 2.7 million of the unemployed lived in single-parent potential Medicaid-eligible families. Subtracting both of these groups from the total yields a population of 2.1 million Americans who are unlikely to have a source of employer- or Medicaid-provided health insurance. This number represents a reasonable -- but lower-bound -- estimate of the totally uncovered population of unemployed family members.

One reason why this population represents the lower bound is obviously that, in certain instances, spouses may have elected to either accept self-only coverage, or may have elected family coverage through the spouse who became unemployed. As I will indicate later, however, this problem can be addressed without great difficulty.

Other Public Programs

We should also note that the total estimate of the unemployed includes many families that are eligible for public assistance, and who therefore qualify for and receive Medicaid coverage. In 22 states, two-parent families can be covered under Medicaid. In 30 states, families can be covered, even if they are not eligible for cash assistance, through "medically needy" programs, wherein high medical expenses are deducted from income to expand eligibility to those who are poor by reason of high medical expenses. While the Medicaid program does require an asset test, the value of the family's home and automobile is not counted for this purpose. In all, those longterm unemployed families most in need of assistance can receive it, in most instances, through existing public sector mechanisms.

Medicaid, of course, is not the sole effort directed at the health care needs of low-income families by the public sector. In the Administration's Fiscal Year 1984 budget, Mr. Chairman, over \$85 billion is provided for health care services -- ranging from community health centers to immunization programs -- to provide health care to those who need it.

Private Sector Efforts

Our present health care system is characterized by voluntary private efforts to provide health care services to those who need it. There is strong evidence that those in the private sector have in fact expanded their efforts during the last few years to meet the needs of those who have become unemployed during the recession.

Private physicians have a long and commendable history of meeting the needs of those with limited resources. As the American Medical Association testified last Friday before the House Health Subcommittee, 70% of all American physicians provide reduced rates or free care services to those unable to afford care. A surprising 10% of all physicians are actually donating their time to special programs for unemployed workers and their families.

Hospitals have been and remain active. As the National Association of Counties has testified before your Committee, 99% of the Nation's largest hospitals provided over \$750 million in uncompensated care in 1980. The evidence available to us suggests that this commitment to providing care regardless of compensation has if anything expanded markedly in the past few years. This sort of commitment, Mr. Chairman, goes far beyond explicit legal commitments, such as the charity care obligations under the Hill-Burton program, to provide free care. Rather, the Nation's community hospitals, which after all are established as private non-profit charitable institutions, have maintained a long tradition of providing care without regard to the ability to pay.

Insurers and other third-party payors have also been active in meeting the needs of the unemployed. In six States, special insurance pools have been established to provide inexpensive coverage to the unemployed. And just last week, Blue Cross/Blue Shield of Western Pennsylvania announced a special program at heavily-discounted rates to unemployed workers and their families.

Coverage for physician services, for example, will cost only \$8.50 per month for full family coverage. Coverage for hospital services will be provided at a 75% discount, both through low rates and by waiver of normal deductibles.

In all, the Administration believes that we must recognize the existence of these commendable efforts as we work to fashion solutions in this area.

AVOIDING LEGISLATIVE OVERKILL

As the foregoing has suggested, the problem of accessible and affordable health care services for unemployed workers and their families really consists of a number of special cases of individuals. Failure to recognize this fact in the development of legislation could prove a costly mistake. As you are aware, Mr. Chairman, the natural tendency of the bill-writing process is to expand consideration to an ever-wider scope of circumstances as special conditions and situational anomalies are brought to light. The danger is that the remedies fashioned to address these anomalies often result in adding in whole new classes of beneficiaries for a program despite the fact that only certain individuals within the stated class may have true needs that cannot be addressed some other way. As I will illustrate, Mr. Chairman, that danger is particularly present in the area of providing health insurance coverage to those who are presently uncovered.

The Dilemma of Equally Worthy Claims

The cause being considered by your Committee is the plight of those unemployed workers who previously had employer-financed health insurance, but lost it as a result of involuntary unemployment. Yet the problem of lack of health insurance coverage is not restricted to this group. There will be a strong temptation for legislative expansion as the circumstances of the target population are compared to the plight of:

- Unemployed families without prior coverage;
- Employed workers with no employer coverage;
- Low-income families with no recent work history who are ineligible for Medicaid; and
- Self-employed workers who receive no special tax breaks for health insurance.

As we learned long ago in the national health insurance debate, our society simply cannot afford to go all the way down this road. Yet if we move forward with an explicit Federal entitlement program in this area, we will be hard-pressed to explain why coverage should be bestowed on a narrow subset of the some 30 million Americans who are without health insurance.

The Minimum-Benefits Problem

A complementary problem with attempting to address the needs of the unemployed through an explicit benefit program is the problem of establishing some minimum acceptable coverage package. On the one hand, the need to restrict costs would argue for some narrowly defined set of benefits -- perhaps restricted to so-called "catastrophic coverage", in which full coverage is provided only after the beneficiary meets some high deductible. Yet the very nature of such coverage would call into question whether any real benefit is in fact being conferred. To the extent that the unemployed have financial problems, the second \$500 dollars of unaffordable expenses is just as insurmountable as the third. Attempting to draw the line in a way that is generally recognized as fair is probably impossible.

It is easy, however, to understand the fiscal stakes involved. Suppose the target population were restricted to 2 million families -- the rough number of families who have lost prior coverage that we estimate will still be on unemployment insurance on October 1. Extremely limited catastrophic coverage might cost perhaps \$20 per month per family, or only \$480 million annually. Yet present employer coverage plans with full benefits -- even at group rates -- can cost over \$180 per month per family. Moving from the low end to the high end of coverage -- a normal tendency in these matters -- could raise costs nearly tenfold to nearly \$4 billion annually.

The Prohibitive Cost of a New Entitlement

If we examine the potential for expansion due to these two factors, we are forced to conclude that any explicit Federal entitlement effort in this area would quickly escalate beyond affordable levels. Providing all eleven million unemployed workers with full family coverage at \$180/month would cost an astonishing \$19 billion annually. Even recognizing that many of the unemployed are single individuals and assuming a blended average cost of full coverage of \$135 per month, the upside threat is in the \$14 billion dollar range. The following table summarizes the potential cost range:

TABLE IV

<u>COST OF COVERING VARIOUS GROUPS WITH HIGH AND LOW OPTION BENEFITS</u>			
<u>Type of Benefit</u>	<u>UI Beneficiaries:</u>		<u>All</u>
	<u>With Prior</u>	<u>All</u>	<u>Unemployed</u>
	<u>Coverage</u>		
	(dollars in billions)		
1) Number in eligible families(millions).....	(4.0)	(5.5)	(17.4)
2) Catastrophic with \$1500 Deductible..... (\$22.50/mo.)	\$0.5	\$0.6	\$2.1
3) Catastrophic with \$500 Deductible..... (\$49.50/mo.)	\$1.1	\$1.3	\$4.6
4) High Option Plan.... (\$180/mo.)	\$4.3	\$5.8	\$18.6

THE ACTUAL FISCAL THREAT IS UNKNOWNABLE

I would caution, moreover, that the Federal government's track record in estimating the cost of new health care entitlements offers little solace as we go forward in this area.

Medicare

Shortly after the enactment of Medicare, the Social Security Trustees Report (1966) estimated that outlays from the HI and SMI trust funds would rise, in real terms, by 5.2% and 2.3% annually, respectively. In fact, the programs grew by 9.3% and 10.2% annually in real terms. As a result, an FY 1988 projection for SMI outlays would have been \$5.6 billion under the original estimates; in fact, we now expect that SMI will hit \$36.5 billion in FY 1988, a 548% overrun from the perspective of the original forecast. Similarly, the original estimate would assume, by 1990, HI outlays totalling \$26.6 billion. The current forecast, however, is for HI outlays to hit \$116.1 billion in 1990 -- a 366% overrun.

ESRD

Even short-run estimating in this area has been fraught with guess-work. The 1973 Social Security Trustees report estimated ESRD costs for Fiscal Year 1974 -- a bare one year later -- at \$65 million-dollars. Actual FY 1974 costs were in fact \$90 million -- a 40% overrun one year out. At that time, the FY 1975 estimate was \$84 million. In reality, FY 1975 spending hit \$167 million -- a 99% overrun two years out. Not surprisingly, spending in FY 1983 is now estimated at \$1.4 billion -- a 2050% increase over the initial FY 1973 cost estimate.

Unknowable Behavioral Effects

The reasons for these overruns are the prodigious incentive effects built into the health care field.

On the beneficiary side, health care is considered such a superior good that consumption is limited only by income. Once a new entitlement is created obviating income limits, utilization of services climbs toward the sky.

On the provider side, the capacity for product upgrading and service improvement is constrained only by aggregate demand for health care services. Once an entitlement is created to fund whatever service consumption level is demanded, the "intensity" of service provided -- more doctors, nurses, supplies and machines -- is limited only by technological advance and labor supply constraints.

First Things First

I would hope, Mr. Chairman, that we have learned our lesson in this field -- that medical care entitlements strain the limits of the largest economy in the world. In fact, recent developments make clear to me that we are hard-pressed to afford the medical entitlements we now have on the books -- let alone being able to afford new ones. As recent studies from all directions have amply demonstrated, the HI trust fund is headed for bankruptcy at some point between 1987 and 1990. In order to stave off bankruptcy of this existing entitlement system, we will somehow have to contend with a projected \$600 billion mismatch between income and outgo to the trust fund between now and the end of the century. This Committee knows well the magnitude of the task before us in either restraining benefits or raising revenues to fund this astronomical shortfall. Adding in new problems will only compound the difficulty of the task.

THE SOBERING FISCAL SITUATION

Even in the best of fiscal circumstances -- such as the halycon days of the late 1960's when the Federal government committed the projected "fiscal dividend" to many worthwhile purposes -- major new entitlement commitments should only be carefully undertaken. In the present environment, with projected deficits stuck permanently in the 5-6% of GNP range in the absence of concerted policy action, the creation of major new entitlement programs would be the height of fiscal irresponsibility. The following table summarizes our current plight in the entitlements area:

TABLE V

PRESENT ENTITLEMENTS COMMITMENTS

<u>Category</u>	<u>1984</u>	<u>1985</u>	<u>1986</u>	<u>1987</u>	<u>1988</u>	<u>Total</u>
(CBO estimates in billions of dollars)						
Total Entitlements	394	418	444	477	511	2,244
SBC Proposed Savings	- 6	- 6	-11	-14	-17	-54
CBO Baseline Deficit	197	214	231	250	267	1,159

As the table shows, the Senate Budget Committee has, to date, been able to find only \$54 billion in entitlement savings out of a \$2.2-trillion spending base -- savings of only 2.4%. Of this amount, \$19 billion has already been achieved as a result of the Social Security reform legislation created by your Committee. Another \$10.7 billion consists of the savings achieved through adopting the Medicare prospective payment provisions as part of the Social Security bill. Apart from these savings, SBC can find additional savings totalling only 1.1%. As a result, under present Senate policy, total entitlement spending will rise by 28% over the next five years. In this environment, further expansions of the entitlements base would be unconscionable.

THE ADMINISTRATION'S VIEWS

For all of these reasons, the Administration would find any new Federal entitlement program in this area totally unacceptable. To meet the needs of those for whom unemployment is a barrier to care, the Administration would instead direct the attention of your Committee to a number of areas in which we believe constructive action can be taken.

Based on our analysis of the scope of the problem, the Administration concludes that there are three classes of unemployed individuals who are presently unable to obtain health insurance or needed health care services:

- Families where one spouse has lost coverage in which the family is unable to reenroll in the health plan of the other working spouse due to restrictive employer open enrollment practices;
- Families which would be able to afford to continue their present coverage or perhaps purchase a less costly plan, but are discouraged from doing so due to the difficulty of finding private market alternatives, or due to considerations of age or illness that make them poor risks; and
- A residual group of long-term unemployed who do not fall in either of the above classes who are ineligible for Medicaid, and unable to avail themselves of other public or private aid.

The Administration believes that the needs of these families can be met by a five-part plan based on the following three principles:

Support & Encourage Private Sector Initiatives

First, the Administration believes that much of the present hardship can be alleviated by constructive actions of the States and the private sector to meet the health care needs of the unemployed. Over the next few months, we plan to call attention to these efforts, and to encourage States and private institutions and individuals to emulate the many commendable efforts already underway. I would urge the Committee to undertake a similar effort, to determine ways in which we at the Federal level can be of assistance in promoting such efforts.

Augmenting Existing Private Insurance Coverage --
Providing Incentives for Increased Access

The Administration will also support efforts through legislation to ensure greater access among the unemployed to private insurance coverage.

Federal Support Tied Directly to New Financing

Third, the Administration will also support budget-neutral efforts to assist those for whom increased access and private sector and State assistance is deemed insufficient. If the Committee determines that increased resources are needed for this purpose, the Administration will support increased funding if and only if the Committee also provides a commensurate level of revenues, beyond those provided for in the President's budget proposals, to prevent increases in the deficit.

Legislative Changes

The specific legislative measures which the Administration would support are:

Mandated Coverage/Conversion Privileges

The Administration would support amendments to the Internal Revenue Code to mandate:

- Continuation of the present employer plan beyond termination, at individual rates at the expense of the former employee, for the lessor of one year or the period of unemployment; and
- An option for former employees to convert to a special low-cost "catastrophic" insurance plan, at market rates at the expense of the former employee, for the same period of eligibility.

The combined effect of these provisions would be to ensure unemployed workers access to a health insurance plan without disqualification for pre-existing conditions or other circumstances. By eliminating the need for the unemployed to seek and out find their own coverages, more families are likely to avail themselves of coverage.

Mandatory Open Enrollment Upon Termination of a Working Spouse

The Administration would also support legislation to ensure that individuals who lose insurance coverage at unemployment can be enrolled speedily in a plan available to their spouses. Specifically, the Administration would support:

- Permitting workers who had previously elected self-only coverage to elect full family coverage when a covered working spouse becomes unemployed; and
- Permitting workers who had previously elected not to accept coverage in favor of enrollment in a working spouse's plan to elect full family coverage should that spouse become unemployed.

As noted earlier, 40% of the unemployed have working spouses. While precise estimates are unavailable, we believe that the combined effect of these provisions will ensure coverage for a significant share -- perhaps as many as one-third -- of the unemployed.

State Assistance Through the Social Services Block Grant

The Administration would also support amendments to Title XX of the Social Security Act to make State provisions for health insurance for the unemployed an eligible activity under the Social Services Block Grant. In doing so, the Administration believes that the broadest possible latitude should be granted to the States to establish eligibility, benefit and delivery mechanism provisions. In that way, States will be able to use the funds available to them to assist those who are uniquely in need of help within their own States.

If the Committee agrees with this recommendation, and wishes to provide added financial resources under that title to the States for this purpose, the Administration could support such increased funding only if additional revenue measures are enacted to finance whatever incremental increase the Committee finds appropriate. Specifically, the Administration would support simultaneous enactment of the Administration's proposed cap on the exclusion of employer contributions from Adjusted Gross Income as an acceptable method of financing. Any funding increase under title XX, however, would have to be matched with a corresponding decrease in the level of the monthly exclusion cap below the level -- \$175/month for family coverage -- that the Administration has proposed.

For example, enacting the cap in 1984 at the \$160/month level would increase revenues in calendar year 1984 by approximately \$500 million above the level assumed in the President's budget.

The Department of Treasury staff stands ready to provide technical assistance to the Committee as it considers these recommendations.

Knowing the Committee's desire to move forward expeditiously in this area, the Administration does not propose that you delay your proceedings further while we prepare draft legislation. Rather, we would welcome the opportunity to work together with the Committee to produce legislation within the scope I have just outlined. We are hopeful, Mr. Chairman, that any legislation developed by this Congress to address the health care needs of the unemployed could be fashioned in a manner that the President could accept. I look forward to working with you and your Committee toward achieving that end, and would welcome any questions that the Committee might have.

Senator QUAYLE. Thank you very much, Mr. Stockman.

I think that we'll try to go as far as a first round and limit ourselves to 10 minutes, and then if anybody wants to ask additional questions, they certainly may.

Mr. Stockman, last Thursday, the Senate went on record in endorsing health benefits for the unemployed, contingent on being financed by revenues. Obviously, in the budget we don't specify what those revenues are, nor do we specify how the benefits are going to be provided. But conceptually the Senate is on record to the tune of about \$200 million in 1983, \$900 million in 1984, and \$700 million in fiscal year 1985.

I do not know of any time during my tenure in office when the Senate agreed to endorse such a temporary program while also agreeing to finance the program appropriately.

Do you endorse what the Senate did last Thursday?

Mr. STOCKMAN. Well, I believe the Senate was headed in the right direction because it did embody those two fundamental principles. I think there's a lot of work yet to be done as to how you design it, how you allocate whatever money is ultimately provided on a State-by-State basis. Since I have suggested throughout my testimony that we can handle most of the problem through the open enrollment provisions and the continuation of coverage provisions, the new Federal money we need has to be highly targeted to the areas of real hardship where you have had major prolonged layoffs, and an exhaustion of either UI benefits or other family resources.

So I think there's a lot of work to be done yet to make sure the targeting formula conforms to the guidance that we've laid out, and to make sure that the block grant is not overly encumbered with Federal mandates as to who is covered, how it is paid for, how it is delivered, and what the benefits structure will be.

Senator QUAYLE. But in principle, you would support what the Senate did last Thursday?

Mr. STOCKMAN. That's correct.

Senator QUAYLE. Have you had a chance, and if you haven't I won't push you on it or has your staff shared with you a tentative outline proposal that we have suggested on the health benefits?

Mr. STOCKMAN. Yes. I've had a chance to analyze that, and I think it is another positive contribution, because it does embody the pay-as-you-go principle, which, as far as I'm concerned, is No. 1 in the priority of importance. It does utilize a block grant.

Now, I'm not sure whether the primary care block grant is a more appropriate vehicle than social services, but I would note that the primary care block grant is a relatively small program, in the range of \$400 million a year, and you would be more than doubling the size of that program and changing the character enormously.

The primary care block grant is primarily the old community health delivery system program that is oriented mostly toward low-income communities, and toward low-income family and outpatient health care delivery needs.

So I think it might be more appropriate to put it through the larger social services block grant with special conditions as to how it's used.

Senator QUAYLE. I agree with you on the primary health care block grant for the reasons you stated and other reasons. And I believe that what we're going to suggest is to put it through the preventive health block grant for a number of reasons, one being I believe that the coverage that we're going to be asking for in the health benefits will be primarily preventive health, and I wonder if you would have any comments on putting it through the preventive health block grant.

Mr. STOCKMAN. Well, Mr. Chairman, I haven't considered that. I think that would be a little more sensible.

Primarily this is a question of which vehicle, and I'm not sure that there are great distinctions between the three block grants that have been discussed.

Senator QUAYLE. The social services block grant concerns me because its focus is in the area of child care. As a matter of fact, I believe that it actually has a prohibition of some sort for health care, at least preventive health care, in the social services block grant.

So we would certainly be changing the character of the social services block grant, and just from a theoretical point of view, if we're implement the program through that block grant. It ought to be implemented through a health block grant, for efficiency's sake, unless there is some strong overriding reason why we ought to use the social services block grant.

I detect from your statement that you don't have any real strong attachment to either block grant, as long as the program is a pay-as-you-go type program, and not an entitlement program. Am I correct in making that conclusion?

Mr. STOCKMAN. Yes, Mr. Chairman. I note that the major distinction among these seems to be the committee of jurisdiction. And recognizing that, I believe that is something that is going to have to be worked out among the committees involved.

Senator QUAYLE. Since you brought that up, if we have a pay-as-you-go-type concept, that would have to be a revenue bill. That means it would have to start in the House Ways and Means Committee.

But if we would report a bill with a block grant, preventive health block grant, and with the contingency that this has to be financed, it would not be a revenue bill, but we would certainly be adopting and subscribing to that philosophy. Therefore, we could move ahead, as far as the Senate side. If you want to look at the Senate moving first, the Senate Finance Committee could not move forward because of the revenue aspects.

Is that correct?

Mr. STOCKMAN. Well, that, I believe is a parliamentary problem of not large difficulty, but some difficulty. However, I want to make very clear that when we speak of pay-as-you-go financing, we mean in the same bill. A contingency tax we're going to get around to passing sometime in the future that will finance this simply won't be acceptable, noting that Congress doesn't seem to have a great affinity for contingency taxes, at least from the debate that we've had since January.

So, this is meant in a literal sense. That the financing and the authorization of expenditures have to be included in the same bill at the same time.

Senator QUAYLE. I certainly understand that and support that conclusion. The only thing I am looking at, as we start to discuss this, is getting a committee of jurisdiction, and going with that committee. We obviously have the jurisdiction and are going in a direction. Obviously we could move. One of the things on which you are adamant, is that this program be based on a pay-as-you-go concept. We would have to join up with the other committees of jurisdiction at some particular time to get a bill that would be satisfactory to you. I wonder, in your statement you talked about a catastrophic package for those who did not have coverage or who could not buy in. Are you going to put any kind of guidelines in there on what the catastrophic package ought to look like or are you going to leave that as an open question?

Mr. STOCKMAN. Well, Mr. Chairman, we have not suggested that, but again, we were eager to cooperate with the Congress. So rather than go through the whole process of detailed bill drafting specification, we have simply recommended guidelines and are now willing to work with the committee to flush them out.

But I think you would have to have some threshold as to what would be considered a low-cost catastrophic plan that would be mandated as part of the package that we are recommending.

Senator QUAYLE. Do you think that the block grant, as such, should emphasize preventive health? Should that be a major emphasis, as we try to determine on how those moneys will be allocated? Should we say preventive health first and then what would be left over to allocate for other things? Wouldn't this be a first priority that we should, in fact, specify?

Mr. STOCKMAN. I think that I would encourage you to stay away from that. The purpose of the money really is to provide health care service delivery to people who are in very hardship circumstances, and that may be in-patient, that may be out-patient, it may be drugs. It is difficult to say, and I do not believe that you want to wire into this some notions of priority of expenditures within the health care system generally.

What we are trying to do is make some resources available on a pay-as-you-go financing to those pockets of extreme hardship and prolonged unemployment that are identified through the targeting formula around the country, and those are going to be pretty serious, acute needs, in many cases, for health services that have not been provided thus far or that were not covered or affordable.

Senator QUAYLE. I suppose it would depend to some degree on how selectively you are going to target, and whether we would actually buy in totality the concept of the employee buying in for additional 12 months. If that, would be adopted, then I would think that you would be looking at a different type of situation.

In our bill, we are talking about providing for the long-term unemployed, those who have been out of work for at least 6 months. It would be a far more general type of coverage, and I think under that circumstance, we might as a committee, want to point the States and the local communities in a direction of preventive health care.

One final question, and then I will yield because my time is up. Enforcement provisions under your proposal are basically through the tax code. Ours would be through the Public Health Service Act, along the lines of the HMO enforcement provisions. Given the attitude of tax simplification today, on which you and, I believe, the President have spoken out. I wonder what would be the relative advantages and disadvantages of having the enforcement of this through the Tax Code, as you are suggesting, or through Public Health Service Act, as we are suggesting.

Have you examined these two avenues? You might point out what are the advantages and disadvantages.

Mr. STOCKMAN. Well, I think they are probably alternate means to achieve the end desire, that is, open enrollment or some kind of continuity of coverage. However, in this case, since we are recommending that the financing come from implementing the tax cap at a lower level than we previously had recommended, I believe it would be desirable to stay with the tax qualification route to achieve these coverages.

As we would view it, the tax excludable status of employer benefits, health benefits, is a major privilege under the tax code, and that in return for a major privilege, which is worth about \$26 or \$27 billion a year in foregone revenue, that limited social policy objectives, in this case providing continuity of coverage for those who are unemployed due to no fault of their own, is a reasonable thing to do.

Rather than get into another statute and more complication, it seems to me it might be desirable to do both at once: impose the tax cap, limit the growth of coverage costs and the misplaced incentives in that, and at the same time require open enrollment and continuity of coverage, as we have defined it.

Senator QUAYLE. Senator Metzenbaum.

Senator METZENBAUM. David, I always enjoy having you come up to testify because you always strain my credulity. I don't know how you can come up with some of the proposals that you make, and I have such difficulty comprehending how you arrive at some of the positions that you take.

But today you are advocating a position that is just unbelievable. You have the average unemployment benefit, which is \$122 a week. The other day we had sitting here at the table a husband and wife and a child very much in need of help who received \$134 a week.

CBO estimates that it takes 28 percent of the average unemployment benefit in order to pay for health insurance, even if they pay at the lower rate as you propose. I think that idea of paying group rates is fine.

Query. Where do they get the money to pay it? You have \$122 a week or even the munificent sum of \$134 a week. How can you possibly pay 28 percent of that and pay for your health insurance coverage even if it is at the rate that the employer was able to buy it compared to the individual rate?

The reason I am so amazed is that it is unrealistic. The money cannot be found. It is just not there in the world in which we live. With the high price of food and clothing, local real estate taxes, and mortgage payments, people in my State are losing their homes,

and they are just not able. Our food distribution programs, our hunger facilities are running out of food, and the Republican mayor of my city says it just is not working.

Yet you come forward with a proposal to pay for the health benefits out of the average \$122 a week that unemployed workers are getting, and I just say: Where do you really think that money is going to come from?

Mr. STOCKMAN. Well, Senator, I think that you have misunderstood what we have recommended. In the case that you describe, which is one of the many cases in the total universe of 12 million unemployed people, it would be very difficult for that family with only \$122 a week, nothing else, not another member of the family working or working spouse or a working spouse that had employer coverage elsewhere, to purchase the entire cost of health insurance coverage during the spell of unemployment. That is why we have recommended direct Federal funding in the form of block grants that would be utilized by the States to assist those families.

But just as your case of the family dependent on a single or sole unemployment check of \$122 a month makes a strong argument for direct subsidy assistance, there are many other cases where families have substantially more resources, income for access to health care than in the case you have described.

For instance, I would note that in the first quarter there were 3.3 million unemployed, married, working spouses that had another working spouse still employed, holding down a job, earning income, and that in a high proportion of those cases, access to the second spouse's employer health plan would be a conceivable way of solving this problem if we changed the tax law to guarantee that that second policy was accessible.

I would also note that unlike the case that you have described, which we are trying to meet with direct subsidies, that 2.4 million of the unemployed in the first quarter of 1983 were dependents, teenagers or relatives who lived in households in which another member of the household was working and holding down a full-time job and presumably had access to health insurance coverage.

So I think my whole argument is: let's break down that group of 12 million people who are unemployed, determine who has coverage already, who needs access to coverage, and who needs access to money, and then fashion a program that provides money where it can be justified because of lack of income or UI or any other source of financing, and provide changes in the Tax Code where the problem is access or where the problem is an inability to convert from one spouse's policy to another when one of the members of the household becomes unemployed. That is all we are saying.

Senator METZENBAUM. Well, you are aware of the fact that if you attempt to convert the spouse's coverage to total family coverage, that that has an economic impact. Somebody has got to pick up the cost, either the employer or the spouse. Somewhere the cost has to be picked up because there is a major spread between the individual coverage and family coverage.

How would you suggest that be funded?

Mr. STOCKMAN. Well, we are recommending that that be internalized in the premium cost to the group plan. Now, you can say this is unfair, that it is putting an additional financial burden on

an employer or the financing cost of a group plan, but, on the other hand, it can be viewed in the opposite way. And that is to the extent that many group plans benefit from two-worker households and the failure of one spouse to elect coverage under that plan, they are getting a cheaper or lower premium financing cost than would be the case if the full rights under the plan were exercised.

So it would wash back and forth over time, and it is just one of those features of reality, two-worker families, potential coverage in two different group plans, that I believe is part of the system and really is not an undue burden to require that either spouse may elect at any time family coverage in the event that one is unemployed.

Senator METZENBAUM. Well, let me just make a comment that many of those 3.3 million spouses who are working are working part time, earning very modest wages. There is a real question of whether they can broaden that coverage when many of them are not even covered by health care benefits. I think that there is something unrealistic about that approach and I do not think it would work, and I do not think that most people who are knowledgeable about the subject would agree that it would work.

Mr. STOCKMAN. Well, Senator, I would note in the bill that you introduced that you provided for open enrollment for spouses. So I thought that we were all agreed on that, and I do not understand what you are saying now: That we should not do that or that other things need to be done in addition to that?

Senator METZENBAUM. Oh, I say we should do it, but I do not think it will realistically help many people.

Mr. STOCKMAN. Well, I have not said it is a total solution. I have said it is one element of a multipronged approach to targeting relief or solutions in the best way possible.

Senator METZENBAUM. Let me talk to you about the other part of your proposal. It has to do with the funding for those cases which you feel it is the obligation of Government to fund. I have difficulty again in this instance in following your thinking because what you are proposing is that the working person or the employer will be charged with the responsibility for saying through increased taxes. You propose that there be a limit as to how much employees may be paid in tax-free health care benefits, and I think your proposal is \$160 a month. Is that the figure that you use?

Mr. STOCKMAN. That is correct.

Senator METZENBAUM. Now, I do not quite follow this. There are a host of areas where you could find this money. You and I have talked about it at Budget Committee hearings. There are various tax loopholes that exist in this country where some wealthy people pay no taxes, where timber companies pay substantially less than that which they should pay, or oil companies pay very modest taxes, or banks have artificial bad debt reserves, where many corporations, including some of these represented at the hearing, are not paying taxes. Sixteen Republican Senators saw fit to write a letter to the President pointing out that 50 percent of the corporations will be paying no taxes by 1985—50 percent paying no taxes by 1985 by reason of the provisions of the 1981 and 1982 tax bills.

You say nothing at all about raising the money in that area, and every time you or the administration propose raising some dollars,

you either do it by doubling the cigarette tax, tripling the telephone tax, adding a nickel a gallon onto the gasoline tax, eliminating or cutting back on the amount that people may deduct as far as their medical expenses are concerned, cutting back on the amount that people may deduct with respect to their casualty expenses. Even your contingency taxes would add 12 cents a gallon to the price that people pay for gasoline and the other proposal, which would be a 5-percent income tax surcharge, is unrealistic because if you do not have to pay any taxes then the 5-percent surcharge is not really a tax at all.

What gets me is that every time this administration talks about finding revenue, you talk about doing it in such a way that it adversely affects middle-income Americans or poor Americans, and I ask you only: Why did you come to the conclusion that this is the particular area that you ought to be taxing in order to raise the money, rather than any one of the various tax loopholes that exist or the various other areas where people just are not bearing their fair share of the tax burden? How did you arrive at this conclusion?

Mr. STOCKMAN. Well, Senator, I know that we have had a number of discussions about loopholes every time that I have come up here over the last 2½ years, and I think we have concluded that loopholes are a relative matter. It depends on how you define some of the underlying—

Senator METZENBAUM. No; you and I agreed on the loopholes, David, because in the Atlantic Monthly article you indicated you and I agreed on the same loopholes, and you told it to the White House, but you did not prevail. We are not in total disagreement.

Mr. STOCKMAN. Well, let me continue.

I would note first that your point as to 50 percent of the corporations not paying taxes in 1985, that probably the major companies in that 50 percent will be the auto companies, the steel companies, and the auto supply companies based in the State of Ohio. Now, the reason they will not be—

Senator METZENBAUM. Republican Senators wrote that letter. I did not make the assertion. They wrote the letter.

Mr. STOCKMAN. Well, I know, but the reason that 50 percent of that group of companies will not be paying taxes is that they will not have any taxable profits, given the huge losses that they have had over the last 3 years and the changes that we made in the tax laws to permit them to carry forward those losses, changes that I believe you and others felt were warranted at the time.

Second, I would note that it is appropriate to make a change in the taxability of health benefits provided through group plans, and the reason for it is that that is a loophole of gigantic dimension that dwarfs many of the smaller ones that equally need to be closed that you talk about now is \$26 billion a year in forgone revenue, and what it means is that we have the most serious kind of inequity built into our tax system today because of the current law regarding health benefits, and gross inequity, as I have understood it, is one of the things that you have recommended that we correct on many occasions.

But let me just give you one example. Two wage earners, each earning \$23,000 a year; one works for an employer who has no

health insurance, pays that employee \$23,000 in cash wages. The second works for an employer covered by the UAW plan, worth about \$3,000 a year in cash equivalent for that health benefit plan. He is earning \$23,000 in compensation as well, but \$3,000 in the form of tax excludable health benefits. Those two workers, presumably doing similar jobs with similar skills, getting the same compensation, will have almost \$1,000 difference in the taxes that they pay to the Federal Government due to the existing open-ended tax exclusion for health benefits.

We are not proposing to abolish that. We recognize that it is grounded in 30 years of history, but what we are proposing to do is cap it so that this inequity can be diminished and so the incentives that this indirect subsidy provides for excessive first dollar coverage will be reduced over time.

Now, the \$175 cap that we have proposed, or a slightly lower level is recommended here, still will only impact about 20 percent of workers in 1984. Eighty percent of workers with employer-provided health insurance receive policies that have premium values of less than \$175 a month. In fact, the average is about \$114.

So we are not radically disrupting the system. We are not making a major change, but we are attempting to get this under control, and in the process do two things: Improve the equity of the Tax Code and, at the same time, provide some incentives for more efficient type coverages in the private health care market.

Senator QUAYLE. Senator Hawkins.

Senator HAWKINS. Mr. Stockman, the dramatic increase in married women entering the work force over the last decade has prompted some innovative techniques, such as the cafeteria plan, for fringe benefits so as to avoid duplicating health coverage for two-earner families, and I understand as your figures said today that 40 percent of those currently unemployed have working spouses.

My concern is: Do you have any statistics that would indicate that for those that have that fringe benefit available to them, that there are difficulties in switching the fringe benefit to convert to health insurance for their family?

Mr. STOCKMAN. Yes; there are difficulties, given the structure of most coverages. Most plans permit change once a year, and, of course, that is at a fixed date, but unemployment is a very unpredictable thing. And so you have a case where it is impossible to make a switch from one type of fringe to another in these cafeteria plans that you talk about at the time when it is needed, that is, when the unexpected unemployment of a spouse occurs.

So the only thing that we are asking here is open enrollment rights any time during the year so if a family has to make a switch in its package of fringe benefits, that can be done when it is needed.

Senator HAWKINS. My State of Florida, as you know, has traditionally opted for bare bones medicaid coverage. Do you have any minimum requirements that a State must meet before they qualify for Federal funds?

Mr. STOCKMAN. Under this block grant that we have recommended, again, I have indicated or we have recommended that it be truly a block grant, which would permit the decisions regarding

coverage and eligibility and whether it is only for the long-term unemployed, defined as 30 weeks or longer, or UI exhaustees or really a dozen other design questions that you would have to face, we would recommend that Congress not preempt these but allow the States to make them on the basis of the circumstances and situations confronted in each State because it is going to be very different.

The situation in Florida is going to be very different than the situation in Pennsylvania, where you have wholesale unemployment in certain localities due to the shutdown of steel plants or other major facilities.

So we would urge that it be as block grant an approach as possible.

Senator HAWKINS. How would persons currently residing in one State, while receiving unemployment benefits or compensation from another State, be handled? We currently have in Florida approximately 76,000 individuals who are receiving unemployment compensations from another State. Would their health benefits be paid for by the State from which they are receiving their unemployment benefit?

Mr. STOCKMAN. Well, I think you could handle that in the targeting formula that allocates the money among the States, and you will inevitably have one factor in that formula, the number of unemployed or the number of UI beneficiaries, and if you define that to include beneficiaries in the State of residence or in the State of origin, that will determine which way the money flows.

So I think since the block grant is designed to provide for the hardship cases, those would be hardship cases where they now reside, that you would want to count those people as in Florida and perhaps not as in Michigan.

Senator HAWKINS. Thank you.

Senator QUAYLE. Senator Nickles.

Senator NICKLES. I have often heard about the people who have driven down to Florida and draw their unemployment and play golf at their resort hotel, and so we will have to watch how these criteria are drawn up.

Senator HAWKINS. They do not have to pay for heating bills.

Senator NICKLES. Mr. Stockman, I am trying to get some kind of scope of the number of people that might be involved. You mentioned a couple of times that there are two, point, some odd people who are working in or who are classified as unemployed but living in a family that had somebody employed, and then also I think where the spouse was currently employed.

How many people would qualify under your criteria who had lost their sole source of income?

Mr. STOCKMAN. Well, I think I can best answer that question, Senator, if you would turn to page 7, table 3. We have tried to break down the unemployed in the first quarter of 1983 by family status, and you have about 5.7 million who are either spouses of working family members or dependents, and then you have 2.1 million who are unemployed sole wage earners, and another 2.7 million who are in single parent families that in some cases would be potentially eligible for medicaid.

In addition to those shown here, you have about 1.7 who are not members of the families, single individuals who are unemployed during the quarter.

So I think if you look at this profile, you can see some of the logic of the multipronged program that we have recommended, and that many of these cases can be dealt with through these modest changes in the tax qualification provisions related to open enrollment and continued coverage availability.

Senator NICKLES. But even looking at that scope, then you would be talking about 2.1 million for unemployed sole wage earners and then another 1.7 that might be single that would not fit into one of the other categories, too.

Mr. STOCKMAN. Yes, but again, there is another crosscut on that, and that is means, availability of other income, and I do not think we should say that this has to be a 100-percent means tested program. But if we keep the Federal funding relatively low, then I believe States will be induced to target their block grant funds to the truly hardship cases where family income and assets and so forth have been exhausted.

Senator NICKLES. I appreciate your statement, and your suggestions regarding block grants and the idea of means testing, although they can be somewhat contradictory. But my problem is that if you narrowed the scope down to sole wage earners, unemployed with no other income source, you came up with a couple of million people in that category. With the health insurance premiums costing \$2,000 a year, we are looking at a \$4 billion program. My concern is if we pass a \$500 million program or a \$1 billion or even a \$4 billion program, and send that out to the States, they will come back within a year and say, "Hey, that is great, but it is just not near enough."

Regardless of the amount of money that is out there, the demand will exceed that amount of money. It would be a very expandable type of a thing and I do not see that there is money to pay for it. I have some reservations about your suggestion to pay for it by reducing the limitation on the premiums. But my biggest reservation would be this ever expanding entitlement program that may start with modest means today, but you and I have seen what some of these modest means programs cost in 10 or 15 years.

Your statement was that our Federal Government is basically bankrupt at this time. Maybe I am putting words in your mouth, but we are. We have a deficit in just the first 6 months of this year of \$129 billion. You know, the States are coming back and saying that they cannot afford many things. Maybe individuals say they cannot afford many things. But the Federal Government cannot afford it either.

So I am very concerned about this inclination that we might have that the Government is the last resort and that we can solve all problems. Certainly pay as you go is a better alternative than none, but I am afraid you might lose that.

Mr. STOCKMAN. Well, Senator, let me respond to that by saying that the pay-as-you-go principle is absolutely essential and inseparable from any acceptable program, and I believe that what will constrain the dollar total and limit this program to one of just hardship assistance and not a broad entitlement that would be

going to many people who have other ways of obtaining coverage is the pay-as-you-go requirement because the bigger the Congress is tempted to make the program, the larger will be the pain imposed to generate the revenues to finance it.

And we simply will not accept legislation now or amendatory legislation in the future in which there is not a credible demonstration of dollar-for-dollar link over the time period for which the program is authorized on the expenditure and the tax financing side.

Senator NICKLES. Mr. Stockman, I appreciate you saying that. I also think of the two other major pay-as-you-go programs that we have. One is medicare and one is Social Security, both of which have ballooned to unbelievable proportions in a very short period of time, both of which you and I know have had very, very serious financial problems.

I think you alluded to the fact that medicare was going to have a \$600 billion shortfall by the turn of the century, an enormous shortfall. So even some of these pay-as-you-go programs as have been initiated by Congress can greatly increase some of our financial problems. I point that out.

Then one comment on the method that you have proposed to pay for it by reducing the amount of deductibility for premiums. I am concerned about that, I guess, from an employer's standpoint. I managed a company, a very small company. It had about 100 employees, but we had a very high incidence of medical problems. We have had several open heart surgeries. We have had cancers, and so on. So our premiums have ballooned right in the vicinity of the maximum that you are talking about today.

Regardless of where that figure is, I am concerned that those premiums are very high not as a result of anybody that is currently working, with the exception of a couple of those individuals. But, you might be penalizing a company that has tried very hard and been very good in working with their employees by saying, "Wait a minute. We are not going to allow you to deduct your medical insurance premiums." They may not be trying to rip off the taxpayers. They just may have very large health and accident premiums because of their experience ratings.

So you may be penalizing those that have already been socked to it with high medical bills and high premiums, and now you are going to penalize them a little bit further by taking away some of that deductibility, when certainly they would wish that their premiums were \$114, but yet they find they are closer to \$200.

Then as this program would increase, you would want to see that or to finance it as you proposed, with the necessity of bringing that back, again, you would put even a greater and greater burden on those surviving employers that maybe are having a hard time surviving in taking away their deductions for expense that they have either contracted for or willingly agreed to.

Mr. STOCKMAN. Well, I appreciate that point, and I think it is a valid criticism. I do not think you can avoid modest injustices when you attempt to change a system that is this big, \$100 billion a year in employer premiums, 69 million people covered, \$26 billion in foregone tax revenues due to the tax-free status.

But, on the other hand, those minor injustices have to be balanced against the major injustice of the current system in which

the self-employed or those who lack employer group coverage receive no tax benefit at all, and as a result, everybody's rates are considerably higher because of this highly unequal treatment between those who happen to be employed in circumstances that permit employer group plan coverages versus those who do not.

That is a far more serious, far greater proportionate injustice than some of the smaller injustice that would have to be corrected if we were to cap it at a relatively high level, and that is why we have proposed transition rules grandfathering in of currently collectively bargained contracts, and so forth. There will be some of that dislocation unavoidably if you impose this cap, but we clearly need it if we are to get the health cost system under control and the revenue hemorrhage to the Treasury reduced.

Senator NICKLES. My time has expired. Could I?

Senator QUAYLE. Go ahead.

Senator NICKLES. Some, I am sure, will offer an alternative method of financing, realizing their scope, that they would like to have it be a multibillion dollar program instead of a few hundred million, and they will suggest payroll taxes. Do you have any comment for that method of financing this type of program?

Mr. STOCKMAN. Well, in light of the fact that it was unavoidable that we needed to increase the payroll tax in the social security package, in light of the fact that last summer in the TEFRA bill there was an implicit increase in the payroll base for the unemployment insurance system, it seems to me we have pushed that just about as far as we want to go without beginning to seriously penalize labor intensive employment in this country, and of course, that is going to have an impact among those where you would least like to see it: the low skilled who are trying to get into the mainstream of our work force.

So I think that that would be a highly undesirable idea.

Senator NICKLES. Thank you very much.

Senator QUAYLE. Thank you very much. Senator Hawkins do you have anything else?

Senator HAWKINS. Well, I would just like to clear up an illusion that maybe Senator Nickles has of the 76,000 people that are residing in Florida drawing unemployment from other States. A great number of them are living in their cars and on the parkway. A situation not to be envied at all. They are looking for work. There is the allure of the Sun Belt that is being ballyhooed by so many journalists and news men, et cetera, telling the unemployed that they can find work there. So they come closer to at least the Sun while they are looking for this.

Senator NICKLES. And play golf.

Senator HAWKINS. I do not know if they play golf. They certainly do play havoc with our society.

Senator QUAYLE. You will probably find some from the State of Indiana, unfortunately, down there. Since they are not finding work there, tell them that we are starting some callbacks and the economy is picking up a little bit in my State.

Senator HAWKINS. We can send them back.

Senator QUAYLE. So you can tell them to come home. We will be glad to have them.

Mr. Stockman, we are going to go ahead and to see what we can do on a committee basis. I certainly appreciate that you have come here today. I understand that your bottom line is that it is going to be a package deal; none of this go ahead and pass the program and say you are going to finance it later. I certainly support that contention, but we have no jurisdiction on the finance area, but we do have some questions about whether it should be the social services block grant or preventive health block grant.

The only request I would make of you, could you designate someone on your staff that we can deal with besides yourself as we go through the markup who would be authorized to give us some direction on what is acceptable and not acceptable as far as the block grant?

Mr. STOCKMAN. I would be happy to do that.

Senator QUAYLE. Would you do that for us?

Mr. STOCKMAN. Right.

Senator QUAYLE. Thank you.

The committee is adjourned.

[Whereupon, at 10:52 a.m., the subcommittee was adjourned, subject to the call of the Chair.]

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ERRATA

Health Care for Displaced Workers Act of 1983

The above hearing before the Senate Committee on Labor and Human Resources was numbered incorrectly.

The correct designation is S. Hrg. 98-333.

S541-32